

CERTIFICATE OF DEATH

Reg. Dist. No. 04161

1. PLACE OF DEATH a. COUNTY <u>Catonsville, Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Nursing Home</u>		d. STREET ADDRESS <u>Box 743</u> <u>XXXXXX Ave. Catonsville, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Bauff</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/1884</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>8</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Ella Duke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mrs. Sadie A. Adams</u>		Address <u>Box 743 Hanover, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insuff</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Huntington's Chorea</u> DUE TO (c) <u>15 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mentally deranged for 14 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 59</u> to <u>April 1962</u> , that I last saw the deceased alive on <u>Mar 31, 1962</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.B. Brumbaugh</u> M.D.		ADDRESS (Street, city or town, state) <u>5609 Main St</u>	
PHYSICIAN'S NAME (Type) <u>B.B. Brumbaugh</u>		DATE SIGNED <u>4/2/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michael's Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St.</u>	
24a. REC'D BY REGISTRAR <u>APR 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04165

04162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore 22 MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AN</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. LENGTH OF STAY IN 1b <i>24 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8226 Bletzer Rd.</i>		d. STREET ADDRESS <i>#1</i>	
3. NAME OF DECEASED (Type or print) <i>MARY First T. Middle ADAMS Last</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>20</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 24. 1888</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Reading, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael SUSKO</i>		14. MOTHER'S MAIDEN NAME <i>Mary Haddock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Self</i>		Address <i>as in #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Adeno Carcinoma Ampulla Vater</i> <i>155.1</i> DUE TO (b) <i>Whipple operation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>2/15/62</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 10</i> 19 <i>61</i> , to <i>April 20</i> 19 <i>62</i> , that I last saw the deceased alive on <i>April 19</i> 19 <i>62</i> , and that death occurred at <i>5:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Tollin</i>		M.D. <i>6908 N. F+Rd</i>	
PHYSICIAN'S NAME (Type) <i>LOUIS N. TOLLIN</i>		DATE SIGNED <i>4/20/62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-23-1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		22d. LOCATION (City, town, or county) (State) <i>Belair Road, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN J. DUDA</i>		ADDRESS <i>7922 Wise Ave. 22, Md.</i>	
24a. REC'D BY REGISTRAR <i>APR 24 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
BOSTON, MASS.
JAN 1 1900

Name of Deceased	
Age	
Sex	
Race	
Marital Status	
Occupation	
Cause of Death	
Place of Death	
Date of Death	
Signature of Physician	
Signature of Registrar	
Signature of Coroner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04166

CERTIFICATE OF DEATH

04163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2731 Arbutus Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STELLA Middle F. Last ADAMS		4. DATE OF DEATH Month April Day 28 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1885
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Boyetown, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jonathon D. Scheeler		14. MOTHER'S MAIDEN NAME Violet Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert S. Adams, Jr.		Address 2731 Arbutus Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan., 1962 to April 28, 1962 , that I last saw the deceased alive on April 27, 1962 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert J. Levickas M.D.		ADDRESS (Street, city or town, state) 2436 Washington Blvd. Baltimore - 30 Md.	
DATE SIGNED 4/30/62			
PHYSICIAN'S NAME (Type) Herbert J. Levickas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/1/62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, Inc.		ADDRESS 715 Light St.	
24a. REC'D BY REGISTRAR MAY 2 1962		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

CERTIFICATE OF DEATH

1918

(M)

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1873		Baltimore, Md.	
Usual Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St.		Teacher		Heart Disease		Feb 10 1918		Home	
Physician		Medical Examiner		Burial Place		Date of Burial		Place of Burial	
Dr. Smith		J. Brown		Cemetery		Feb 15 1918		Catholic	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Coroner		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
BALTIMORE
FEB 15 1918
STATE DEPARTMENT OF HEALTH

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled out by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04164

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>CATONSVILLE</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>613 BRAESIDE RD.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>613 BRAESIDE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BESSIE MARIE ANDERSON</u>				4. DATE OF DEATH Month <u>APR.</u> Day <u>22</u> Year <u>1962</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 14, 1899</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER, PUBLIC SCHOOLS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. VA.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL V. THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. WORMAN.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>213-44-8094</u>		17. INFORMANT Address <u>MR. WILLIAM ANDERSON (SON)</u> <u>5302 EDMONDSON AVE.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Renal Disease</u> DUE TO (b) <u>Chronic nephritis.</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 18, 1956</u> to <u>April 22, 1962</u> that (I) (we) last saw the deceased alive on <u>April 21, 1962</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry L. Knipp</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY L. KNIPP, M.D.</u>				22d. ADDRESS <u>4116 Edmondson Ave. Balto. 29, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		23d. LOCATION (City, town or county) (State) <u>WOODLAWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, 4101 EDMONDSON AVE.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

2210

TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04168

04165

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4820 Eldon Green		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4820 Eldon Green e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth F. Bacon		4. DATE OF DEATH Month April Day 18 , Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1922
9. AGE (In years last birthday) 39		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Donald C. Stickell		14. MOTHER'S MAIDEN NAME Edith G. Hess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Franklyn C. Bacon, 4820 Eldon Green #27		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Carcinoma of Breasts 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1956 to April 18, 1962, that (I) (two) last saw the deceased alive on April 16, 1962, and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE I. Earl Pass, M. D.		22b. DATE SIGNED 4-18-62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 4001 Wilkens Avenue, Balto. 29, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/20/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE William E. Thomas			

04162

04168

(M)

International Commission on the History of the

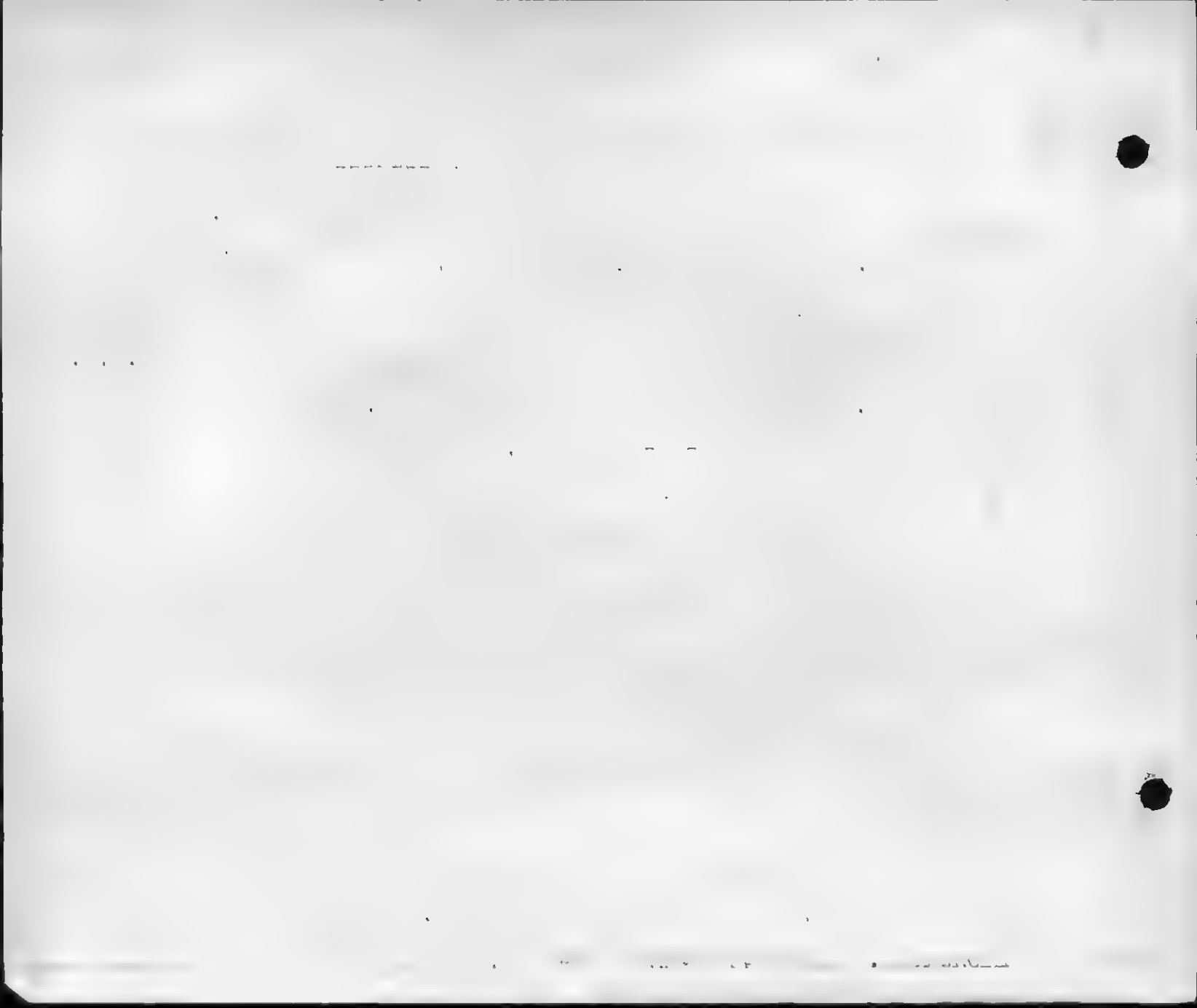
Cartography

Altores
London Park County, Idaho, 1912

Library of Congress, 1001 North Capitol St., Washington, D.C. 20540

DATE _____

VR A15 (4)
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VR A15 (4)
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TO HOSPITAL



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04168

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (if outside of corporate limits write RURAL and give nearest town) WOODLAWN
c. LENGTH OF STAY IN IL LIFE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2016 OAK DRIVE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD
b. COUNTY BALTO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.
d. STREET ADDRESS 3201 STRICKLAND ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) ANNA B. BAXTER
First Middle Last
4. DATE OF DEATH APR. 28, 1962 Month Day Year
5. SEX F.
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH JUN. 6, 1892 69 yrs.
9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK,
10b. KIND OF BUSINESS OR INDUSTRY MAY CO.
11. BIRTHPLACE (County & State, or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME LOUIS SCHLISING
14. MOTHER'S MAIDEN NAME CATHERINE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐
16. SOCIAL SECURITY NO. 216-245582
17. INFORMANT MRS CATHERINE E. STAPPER Address 2016 OAK DRIVE, BALTO. 7, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lympho Lymphosarcoma c General
(b) Abdominal Metastasis
200.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/3 to 4/28, 1962, that (I) (we) last saw the deceased alive on 4/24, 1962, and that death occurred 4/28, from the causes and on the date stated above.

22a. SIGNATURE Eliot W. Johnson M.D.
22c. PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON MD
22d. ADDRESS 3432 JENNIFER AVE BALTIMORE 29 MD
22e. DATE SIGNED 4/28/62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 5/1/62
23c. NAME OF CEMETERY OR CREMATORY LOUDON PK CEMT.
23d. LOCATION (City, town or county) (State) BALTO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE WITKE, 4101 EDMONDSON AVE. ADDRESS
25a. REC'D BY REGISTRAR DATE MAY 1 '62
25b. REGISTRAR'S SIGNATURE C. Thur S. Hume



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04169

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phenix Md.		c. LENGTH OF STAY IN 1b 4 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stockton Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Delores Last Beale		4. DATE OF DEATH Month April Day 22 Year 1962	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/1961
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 22 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md. (Baltimore)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Beale		14. MOTHER'S MAIDEN NAME Edith Beale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Beale		Address Stockton Rd. Phenix, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by aspiration of food 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A. M. France		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) A. M. FRANCE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/62	22c. NAME OF CEMETERY OR CREMATORY STVENSON CEMETERY	22d. LOCATION (City, town, or county) (State) Sparks Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. JACKSON		ADDRESS Fun Home Inc. Balto, Md.	
24a. REC'D BY REGISTRAR APR 25 62		24b. REGISTRAR'S SIGNATURE Arthur J. France	



TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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04173

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04170

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4y110mth23dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
f. STREET ADDRESS <u>1402 Patapsco Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Selma</u> Middle <u>Berigtold</u> Last <u>April</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 62</u>			
5 SEX <u>female</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life.) <u>housewife (cashier)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>New York, N. Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Isadore Lippman</u>				14. MOTHER'S MAIDEN NAME <u>Fredericka Gerstenberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-20-0624</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) <u>diabetes - arteriosclerosis heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>long standing</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic brain syndrome due to arteriosclerosis, malnutrition, dehydration</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 3, 1957</u> to <u>April 30, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 30, 1962</u> , and that death occurred at <u>11:55 P. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u>		22b. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 26, Maryland</u>		22c. DATE SIGNED <u>5-1-62</u>	
23a. BURIAL CREMATION, ETC. <u>BURIAL</u> (Specify)		23b. DATE THEREOF <u>5-3-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

M





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04171

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balt c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 922 Leeds Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) COLUMBUS First GUSTAVUS Middle ADOLPHUS BLEN GUSTAVE ADOLPH BLEN		4. DATE OF DEATH Month April Day 29 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-92	9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY self-employed Plumbing Company		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME John Bien		14. MOTHER'S MAIDEN NAME MARY THOMAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 216-32-8185		17. INFORMANT Clinical Records VAH Fort Howard Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (b) PASSIVE CONGESTION LIVER, SPLEEN, KIDNEYS (c), stating the underlying cause last. 420.0		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TERMINAL BRONCHO PNEUMONIA BILATERAL				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28, 1962 to April 29, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 29, 1962 , and that death occurred at 8:20 p.m. from the causes and on the date stated above.				
22a. SIGNATURE 		22b. DATE SIGNED 4-30-62	22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/62	23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24b. ADDRESS Funeral Home 3331 Bröhms Lane	25a. REC'D BY REGISTRAR MAY 2 '62	25b. REGISTRAR'S SIGNATURE 
23d. LOCATION (City, town or county) (State) Baltimore, Md.				

1. 1. 1.

2. 2. 2.

3. 3. 3.

4. 4. 4.

5. 5. 5.

6. 6. 6.

7. 7. 7.

8. 8. 8.

9. 9. 9.

10. 10. 10.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04172

1. PLACE OF DEATH

a. COUNTY

Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

b. COUNTY

Md Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

5 Overbrook Ave John William Borchers Sr.

Middle

5 Overbrook Ave
Last
4. DATE OF DEATH

Month **April** Day **23** Year **1962**

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Oct. 24, 1902

9. AGE (In years last birthday)

59 yrs

IF UNDER 1 YEAR, IF UNDER 24 HRS

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired)

Butcher

10b. KIND OF BUSINESS OR INDUSTRY

Meats

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Henry H. Borchers

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Not known) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Margaret Borchers

Address

5 Overbrook Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Pulmonary Hemorrhage

DUE TO

Cancer of the Lung

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

Operation Oct. 3-61 on Lung removal of growth

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

EXAMINER'S NAME (Type)

Geo. S. M. Kieffer M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

#1616 Leeds Ave. 4-22-62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Burial

4-25-1962

Western Cemetery

Baltimore - Maryland

23. FUNERAL DIRECTOR

ADDRESS

24a. REG'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

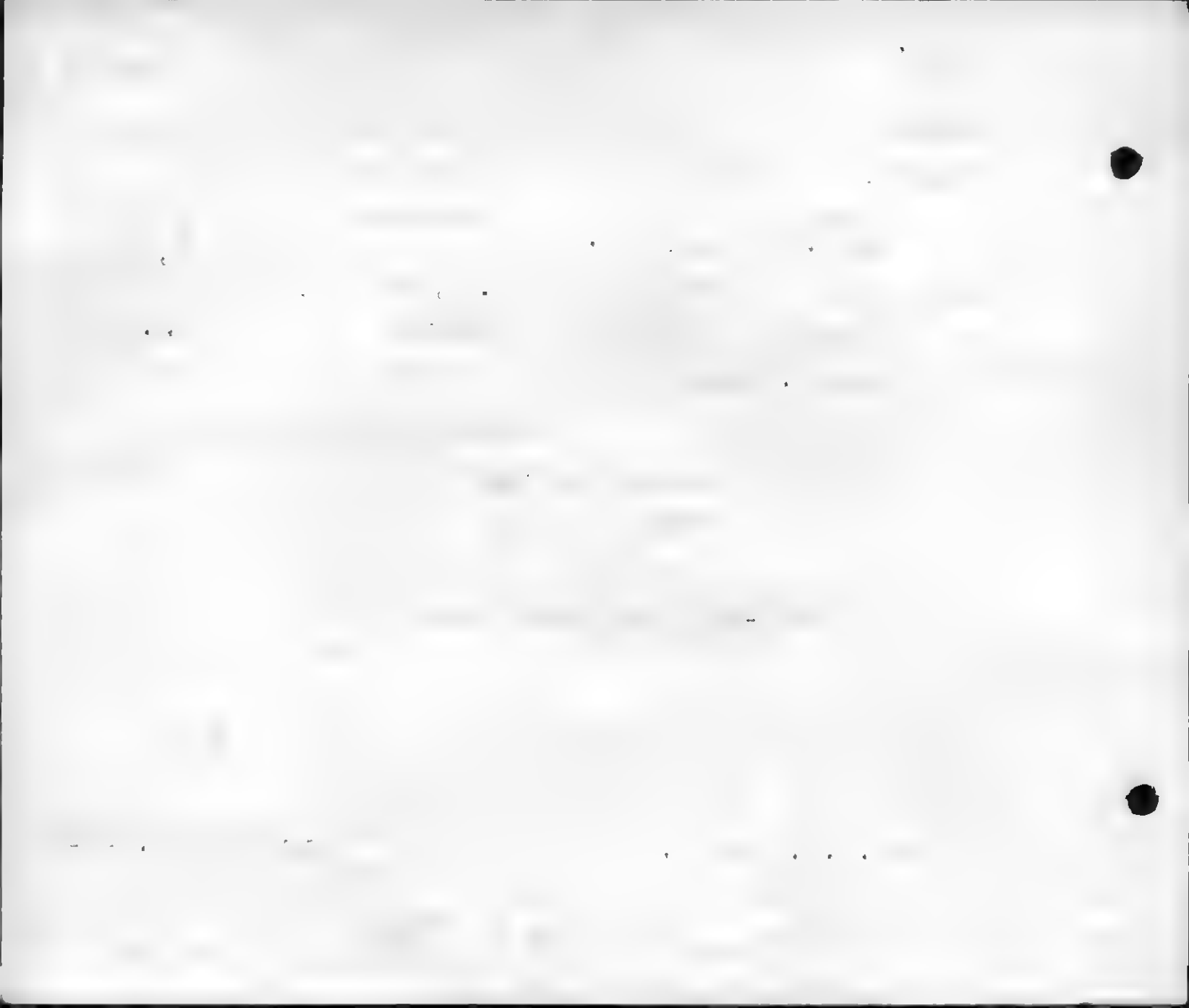
Mac Nuts for 301 Redbank Road - 28

DATE

APR 26 '62

Arthur J. Thomas

TO DEPUTY CHIEF EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

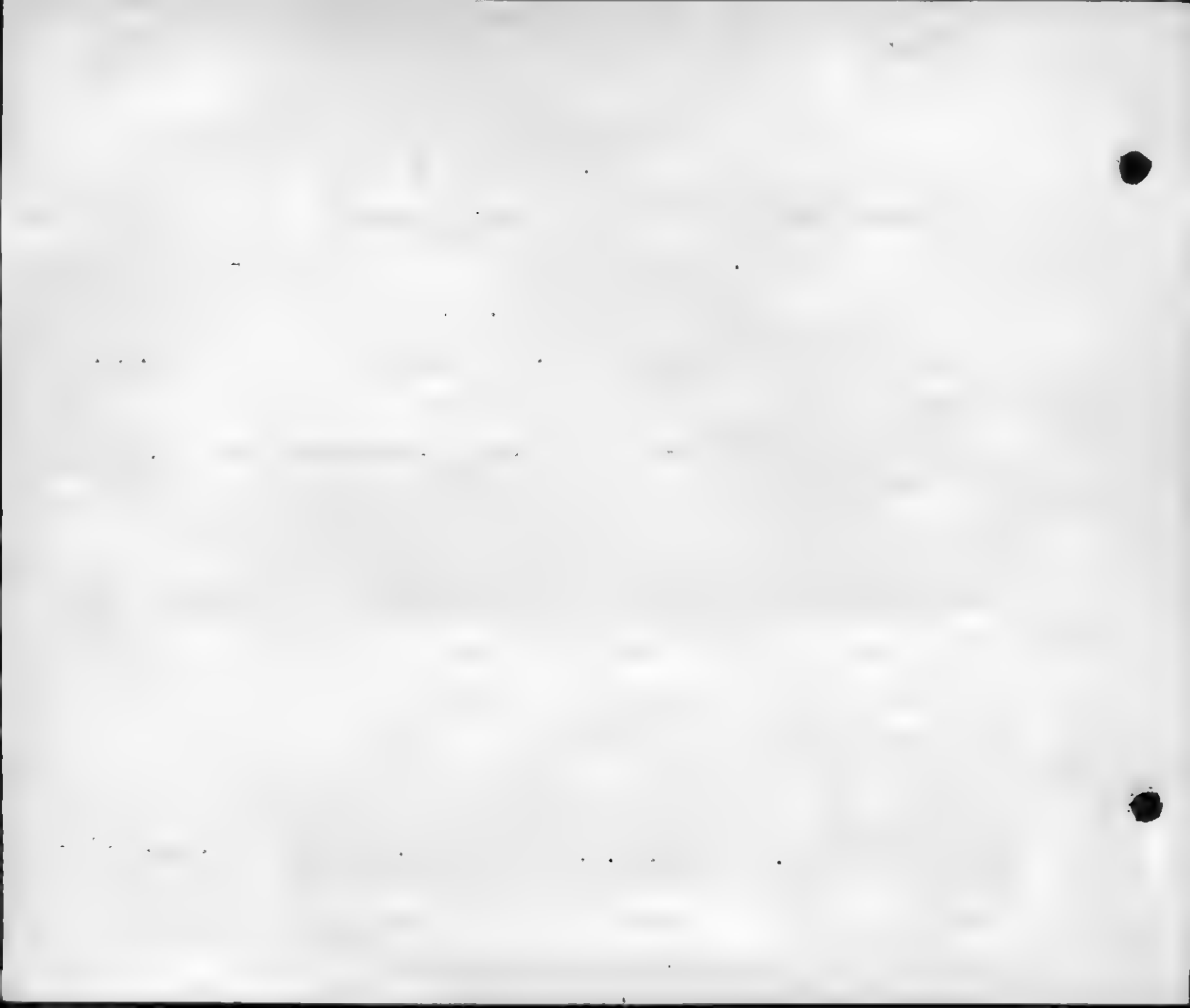
14
FOR STATE
HEALTH DEPT.
M

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04174

1. PLACE OF DEATH a. COUNTY Balto Co b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Baltimore 7 c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7500 Marston Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Baltimore 7 d. STREET ADDRESS 7500 Marston Rd	
3. NAME OF DECEASED (Type or print) Curtis C. Bradshaw		4. DATE OF DEATH Month 4- Day 17 Year 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1898
9. AGE (in years last birthday) 64 yrs.		10. IF UNDER 1 YEAR: Months 4 Days 17 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY American Can Co.	
11. BIRTHPLACE (State or foreign country) Smith Island, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W W I		16. SOCIAL SECURITY NO. 158-09-76261	
17. INFORMATION Mrs. Ruby E. Bradshaw, Baltimore 7, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Martin E. Strobel		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Martin E. Strobel, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or country) Baltimore, Maryland	
23. FUNERAL DIRECTOR Loring Byers		24a. REG'D BY REGISTRAR APR 19 62	
ADDRESS 8728 Liberty Rd; Randallstown Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>04177</div> <div> <div>1</div> <div>04177</div> </div> <div> <div>04177</div> <div>04173</div> </div>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)					
a. COUNTY Baltimore MARYLAND						a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,				c. LENGTH OF STAY IN 1b 11 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 43 Burke Ave.						d. STREET ADDRESS 43 Burke Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Annabel Middle Stein Last Brandt						Month 4 Day 14 Year 19 62					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-1885		9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Penn.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ????? Stein						14. MOTHER'S MAIDEN NAME Elizabeth Herbig					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Clarence Brown				Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div> <div> <div>430-1</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Myocardial Infarction</div> <div>DUE TO</div> <div>(b)</div> <div>DUE TO</div> <div>(c)</div> </div> <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> </div> </div> </div>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 10/20 , 19 59 , to 4/14 , 19 62 that (I) (was) last saw the deceased alive on 4/14/62 and that death occurred at 12 M. from the causes and on the date stated above.											
22a. SIGNATURE W. M. Smith				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. ADDRESS 6305 THE ALAMEDA BALTO					
22c. PHYSICIAN'S NAME (Type) W. M. Smith M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-17-62		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION (City, town, or county) (State) Summerton, Penn.			
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc., Towson 4, Md.						25a. REC'D BY REGISTRAR DATE APR 16 '62		25b. REGISTRAR'S SIGNATURE Wm. S. Thayer			

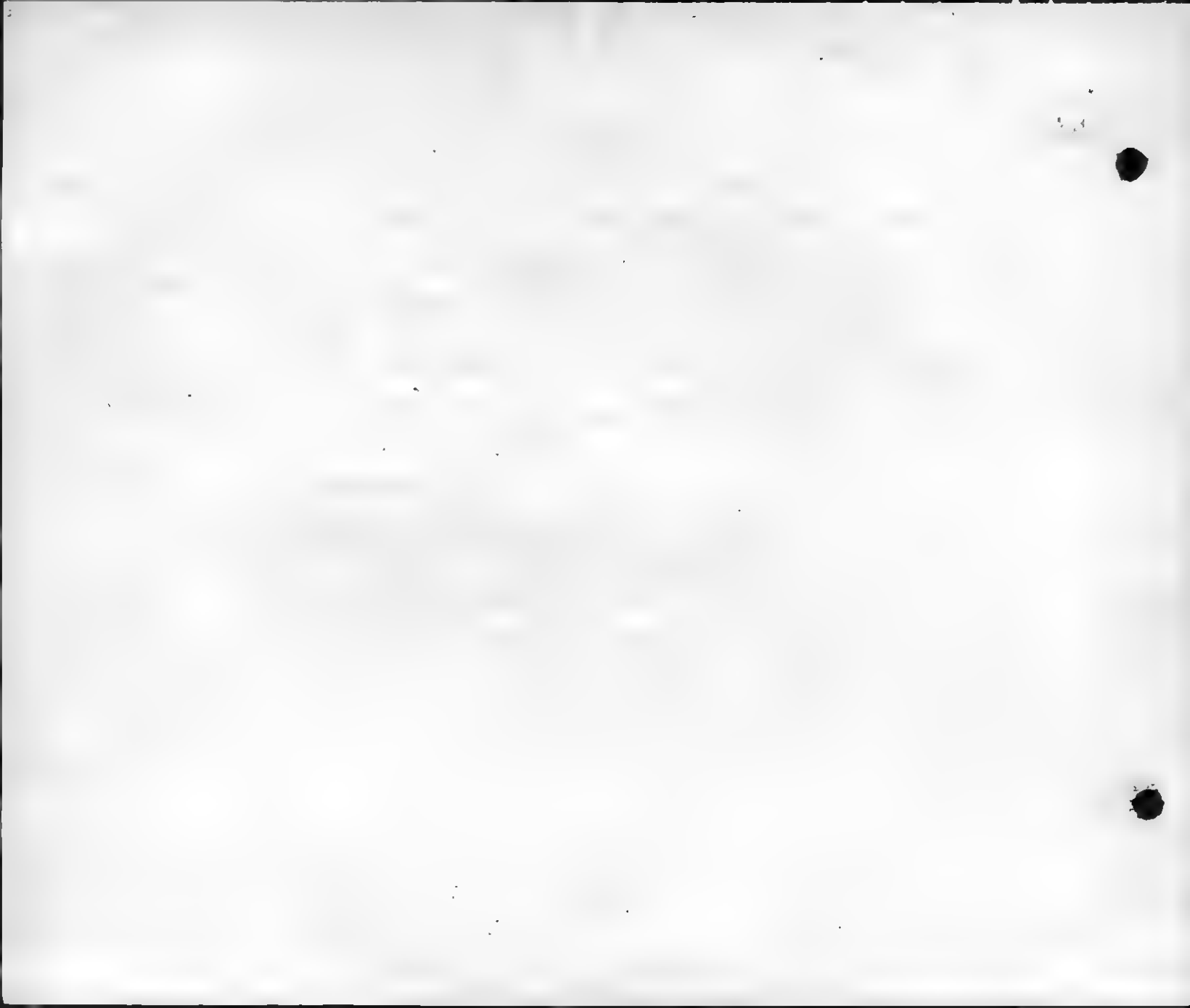


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb BALTO.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ARMACOST NURS. HOME.		d. STREET ADDRESS FORMERLY OF 4904 ALSON DR.	
3. NAME OF DECEASED (Type or print) MARGARET E. BRENNAN		4. DATE OF DEATH APR. 29, 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH JULY 12, 1875	9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (County & State, or foreign country) MD.
13. FATHER'S NAME THOMAS BRENNAN		14. MOTHER'S MAIDEN NAME MARGARET MITCHELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MISS MARGARET E. BRENNAN, 320 E. BELVEDERE AVE.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Cardio-Renal Vascular Disease	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/29, 1962 to 4/29, 1962 , that (I) (we) last saw the deceased alive on 4/29, 1962 , and that death occurred at 7:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE Charles F. O'Donnell		22b. DATE SIGNED 4/30/62	
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell MD 2101 York Rd #4 MC		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/1/62	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City, town or county) (State) BALTO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE WITKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR DATE MAY 2 '62	
		25b. REGISTRAR'S SIGNATURE Charles S. Hanna	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04179

04176

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u> c. LENGTH OF STAY IN b. <u>6 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Zion Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u> d. STREET ADDRESS <u>Mt. Zion Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace E. Brent</u> First Middle Last 4. DATE OF DEATH <u>April 21</u> 19 <u>62</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 11 1886</u> 9. AGE (In years, last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. Fe.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Cockeysville, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles W. McCann</u> 14. MOTHER'S MAIDEN NAME <u>Virginia Ayres</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>443X</u> 17. INFORMANT <u>Virginia Ayres</u> Address <u>Freeland, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from... <u>1959</u> to <u>4/21</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on... <u>4/20</u> 19 <u>62</u> , and that death occurred at <u>9:20 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>A. M. France</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/21/62</u> 22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u> 22d. ADDRESS <u>PARKTON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 24 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Freeland, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u> 25a. REC'D BY REGISTRAR <u>APR 24 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the funeral. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
e. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
f. STATE
g. COUNTY
h. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
i. STREET ADDRESS
j. DATE OF DEATH
k. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
l. BIRTHPLACE (County & State, or foreign country)
m. CITIZEN OF WHAT COUNTRY?
n. FATHER'S NAME
o. MOTHER'S MAIDEN NAME
p. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
q. SOCIAL SECURITY NO.
r. INFORMANT
s. ADDRESS
t. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
u. PART I. DEATH WAS CAUSED BY:
v. IMMEDIATE CAUSE (a) (b) (c)
w. DUE TO
x. CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.
y. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
z. WAS AUTOPSY PERFORMED? YES NO
aa. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
ab. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
ac. TIME OF INJURY Month, Day, Year
ad. INJURY OCCURRED While Not While
ae. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
af. (City or town) (County) (State)
ag. I certify that (this hospital) attended the deceased from March 28 1962 to April 3 1962 that (we) last saw the deceased alive on April 3 1962 and that death occurred at A.M. from the causes and on the date stated above.
ah. SIGNATURE
ai. PHYSICIAN'S NAME (Type)
aj. BURIAL, CREMATION, REMOVAL (Specify)
ak. DATE THEREOF
al. NAME OF CEMETERY OR CREMATORY
am. LOCATION (City, town or county) (State)
an. REC'D BY REGISTRAR
ao. REGISTRAR'S SIGNATURE
ap. DATE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 23b Film G311 4/19/62 mb

04180

04177

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN b

6 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore 13

d. STREET ADDRESS

1202 North Curley Street

a. 15 RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

CLARENCE

J.

BROWN

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 31, 1930

9. AGE (In years last birthday)

31 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Porter - Hospital

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Clarence C. Brown

14. MOTHER'S MAIDEN NAME

Ruth Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

Mexican

16. SOCIAL SECURITY NO.

220-20-3500

17. INFORMANT

Clinical Records

VA HOSPITAL, FORT HOWARD, MARYLAND

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

RIGHT LOWER LOBE PNEUMONIA

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(e) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from March 28 1962 to April 3 1962 that (we) last saw the deceased alive on April 3 1962 and that death occurred at A.M. from the causes and on the date stated above.

22a. SIGNATURE

SEBASTIAN RUSSO, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

4/3/62

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

VA HOSPITAL, FORT HOWARD, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

April 6-62

23c. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

23d. LOCATION (City, town or county)

Baltimore 28, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Elroy O. Wilson

ADDRESS

1000 Brantley Ave.
Baltimore 17, Md.

25a. REC'D BY REGISTRAR

DATE APR 13 '62

25b. REGISTRAR'S SIGNATURE

William L. Harris



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

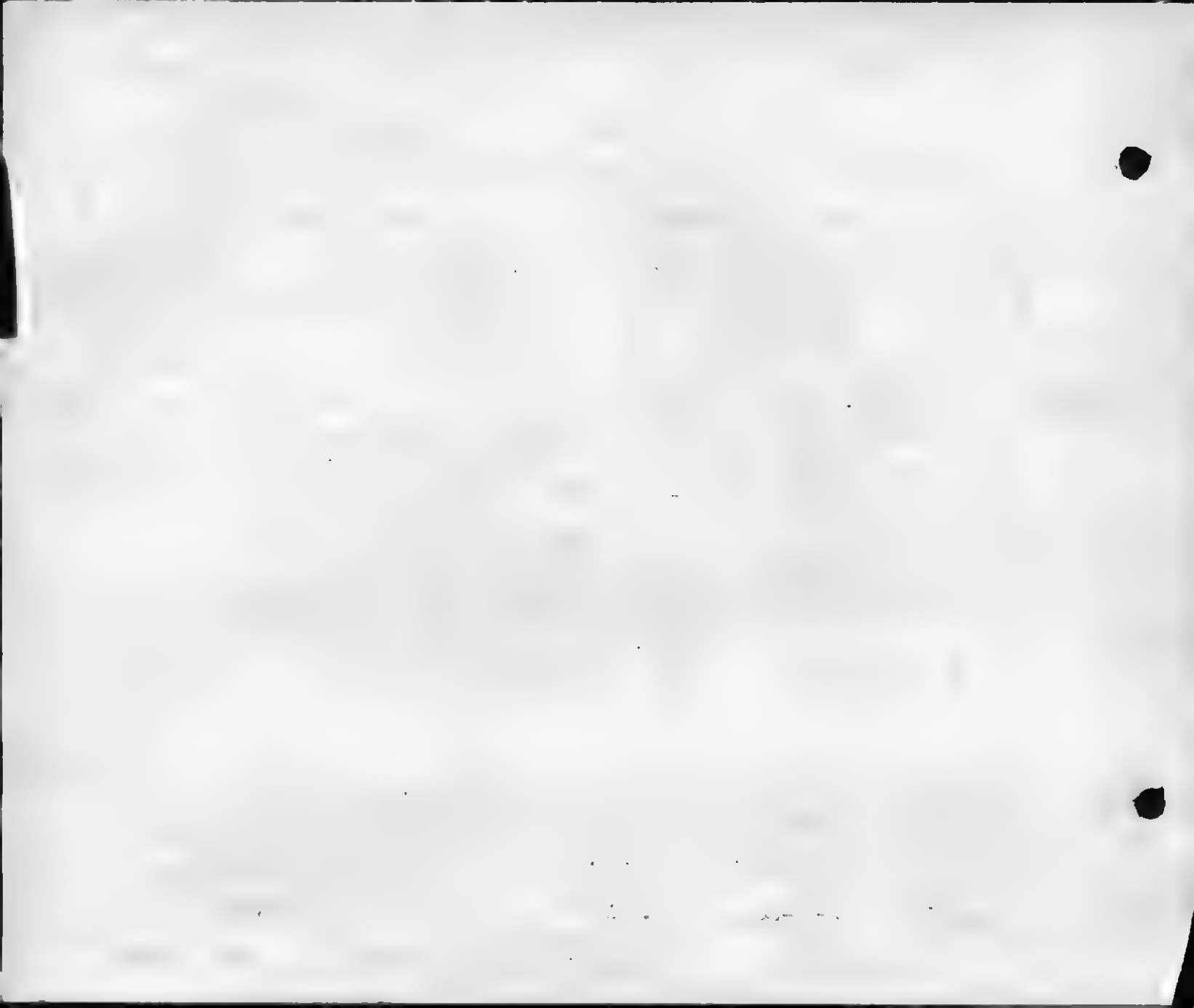
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04178

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>226 Main St</u>		d. STREET ADDRESS <u>226 Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Grace M. Brown</u>		4. DATE OF DEATH <u>April 20 - 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1882</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>was</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Daughter</u> Address <u>Edna Kenny - 226 Main St. Reisterstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>4:41</u> DUE TO <u>lost broken pharyngeal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Constrictive heart disease</u> (c) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>5 hrs</u> <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A leukemic leukemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1958</u> to <u>April 20, 1962</u> , that I last saw the deceased alive on <u>April 17, 1962</u> , and that death occurred at <u>2:25 PM</u> , from the causes, and on the date stated above.			
ACTUAL SIGNATURE <u>Martin J Feldman M.D.</u>		ADDRESS (Street, city or town, state) <u>1 Cherry Hill Rd Reisterstown Md 21116</u>	
PHYSICIAN'S NAME (Type) <u>Martin J Feldman M.D.</u>		DATE SIGNED <u>April 22, 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4-23-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Graveside</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A Newell</u>		ADDRESS <u>Pikesville Md</u>	
24a. RECEIVED BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	





TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

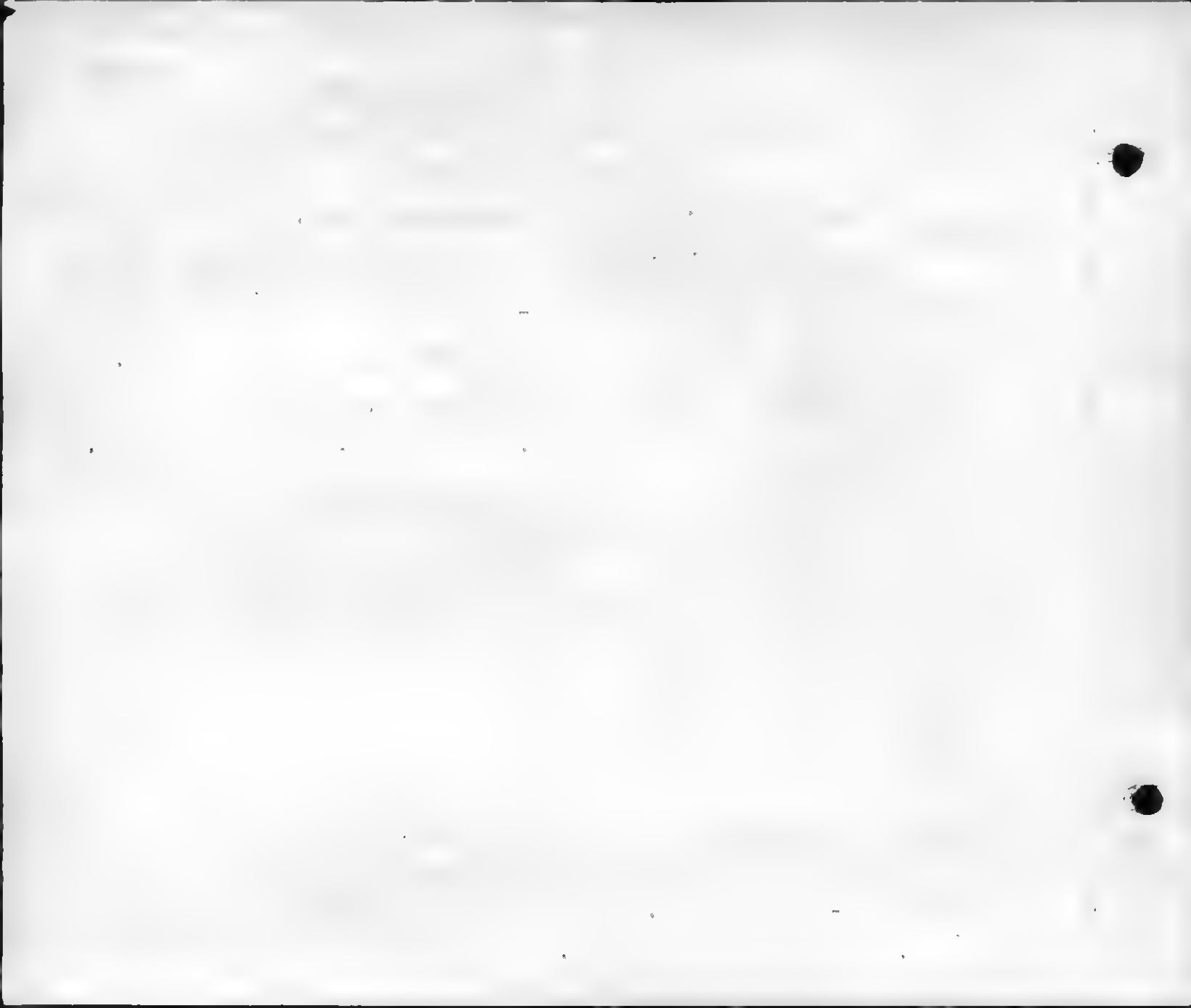
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04183

04180

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
c. LENGTH OF STAY IN IL 40 Yrs		d. STREET ADDRESS 104 Sherwood Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 104 Sherwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Hannah Buckman		4. DATE OF DEATH April 15, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-16-1884	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Rhodes		14. MOTHER'S MAIDEN NAME Florence H. Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 5-20-1	
17. INFORMANT Mrs. Grover Cook, 3712 Lochearn Dr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Disease (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Explosion during sleep	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20, 1962 to April 15, 1962 that (I) (we) last saw the deceased alive on March 20, 1962 , and that death occurred at 5AM , from the causes and on the date stated above			
22a. SIGNATURE Sheldon Keylow		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell Pikesville, Md.		25a. REC'D BY REGISTRAR APR 16 1962	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		25c. DATE	



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TO HOSPITAL death. Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

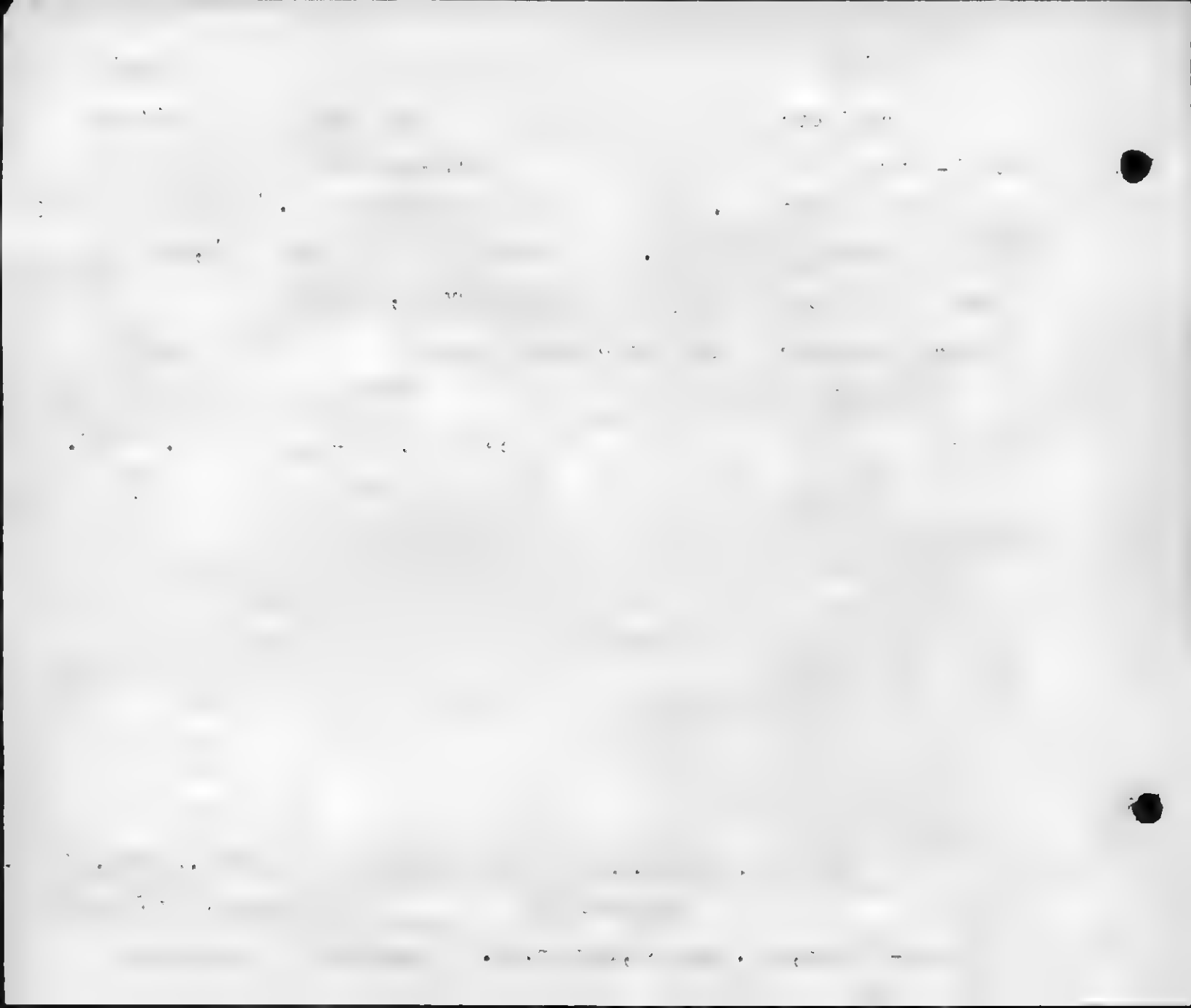
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04184

CERTIFICATE OF DEATH

04181

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Towson c. LENGTH OF STAY IN b X Rural-Towson d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10 Gunpowder Rd. 34		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-Towson d. STREET ADDRESS 10 Gunpowder Rd. 34 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK D. BURHOP		4. DATE OF DEATH Month April Day 24 , Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10, 1877
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months 9 Days 5 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired exporter		10b. KIND OF BUSINESS OR INDUSTRY Tea and Coffee	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO Frances Pottberg-Glen Arm Rd. 34, Md.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Aortic Stenosis (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus	
19. INTERVAL BETWEEN ONSET AND DEATH 9 months 5 years + 10 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from August 1957 to April 23, 1962 that (I) (the) last saw the deceased alive on April 23, 1962 and that death occurred 6:15A from the causes and on the date stated above.			
22a. SIGNATURE Charles E. Shaw M.D.		22b. DATE SIGNED Apr 24, 1962	
22c. PHYSICIAN'S NAME (Type) CHARLES E. SHAW, M.D.		22d. ADDRESS 5801 Loch Raven Blvd., Balto. 12, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/62	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION (City, town or county) (State) Flemington, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. York Rd, Towson, Md.		25a. REC'D BY REGISTRAR DATE APR 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hays			



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

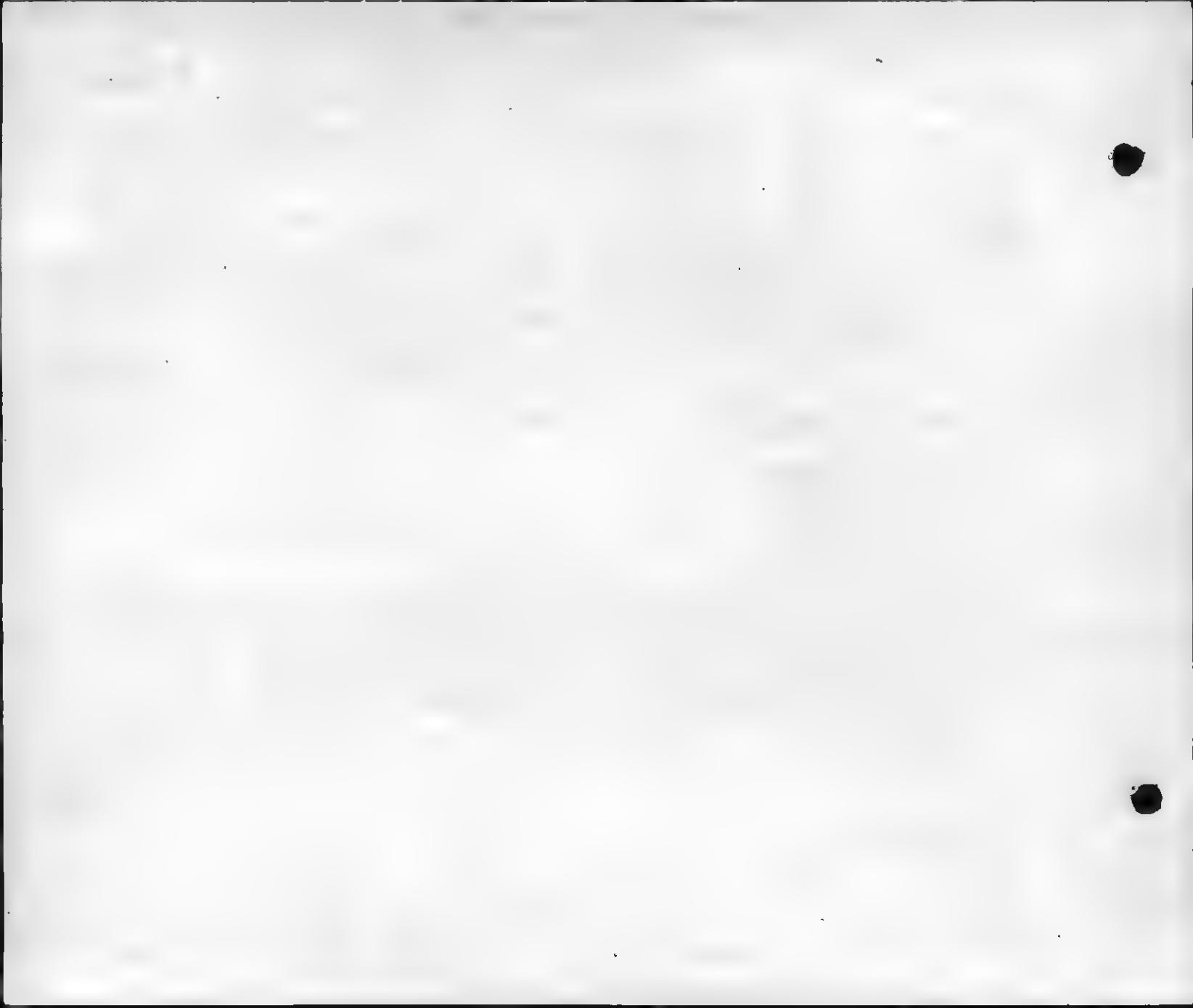
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04185 CERTIFICATE OF DEATH 04182

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2980 Cornwall Road		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2980 Cornwall Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN THOMAS BUSCH First Middle Last		4. DATE OF DEATH April 11, 1962 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1872 9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Busch		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. James L. Stephenson Address 2980 Cornwall Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162.01 DUE TO Bronchogenic Carcinoma of the Lung with generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1962 to April 11, 1962 that (I) (we) last saw the deceased alive on April 4, 1962 and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Eugene F. Nevey		22b. DATE SIGNED 4/13/62	
22c. PHYSICIAN'S NAME (Type) EUGENE F. NEVEY		22d. ADDRESS 7001 MORNINGTON ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 14, 1962	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR APR 18 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

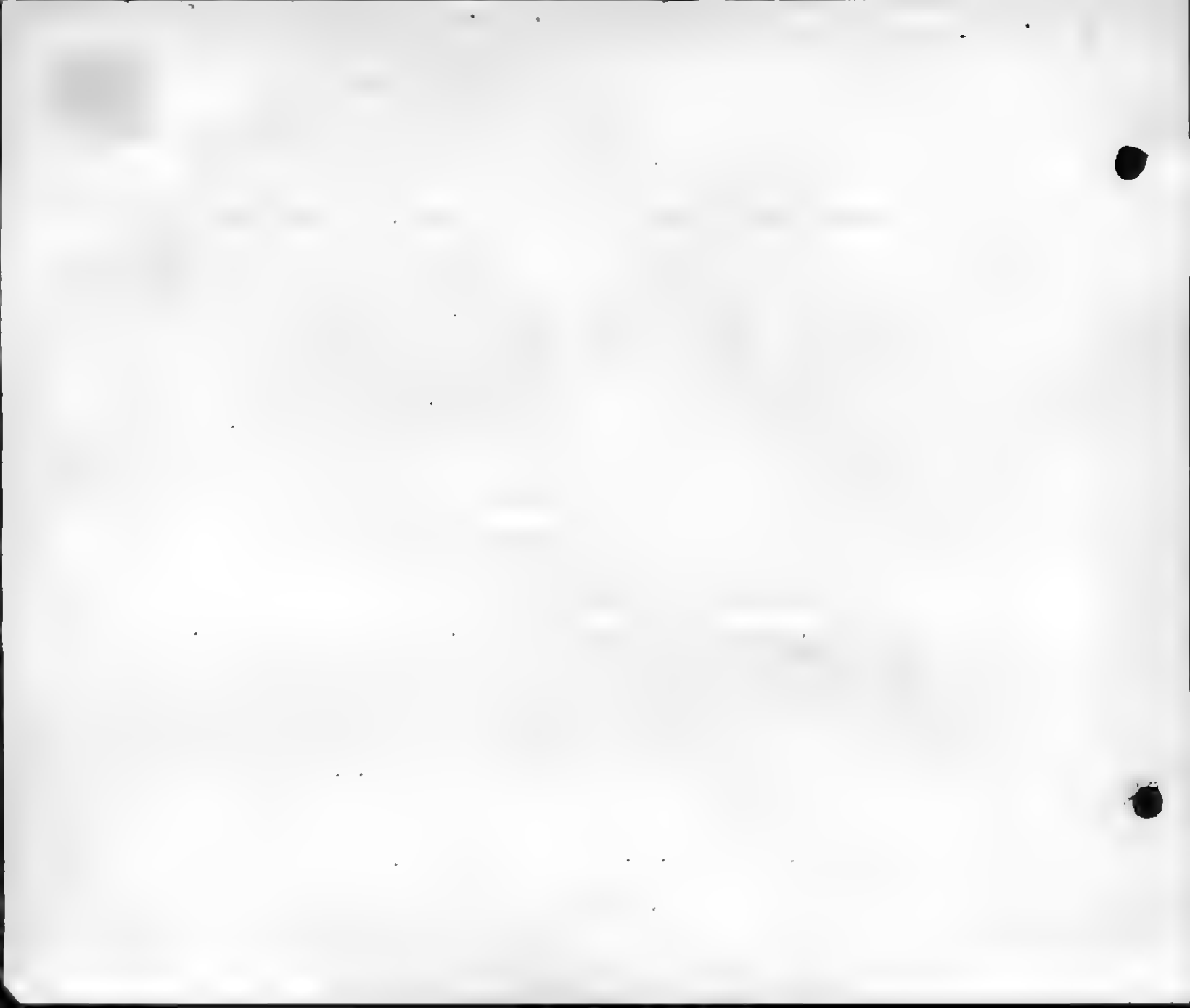
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04186

CERTIFICATE OF DEATH

04183

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND		c. LENGTH OF STAY IN b. 50 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1947 W. MULBERRY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
VETERANS ADMINISTRATION HOSPITAL													
3. NAME OF DECEASED (Type or print) THOMAS H. BYRD		First Middle Last		4. DATE OF DEATH APRIL 26 1962		Month Day Year							
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1894		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Smelting & Refining Co		11. BIRTHPLACE (County & State, or foreign country) Surrey Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Doctor Byrd				14. MOTHER'S MAIDEN NAME Mary J. Morgan									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 212 10 1454		17. INFORMANT Clinical Records, V. A. Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 43 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADENOMA, THYROID, BENIGN PROSTATIC HYPERTROPHY, PULMONARY EMPHYSEMA, INCISIONAL WOUND RECENT, LEFT KNEE												INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN	
20a. ACCIDENT OR UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 62 Hour a.m. p.m. 8:30A.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) md (State)							
21. I certify that 1 (this hospital) attended the deceased from March 7 1962 to April 26 1962 , that 1 (we) last saw the deceased alive on April 26 1962 , and that death occurred at 8:30A.M. from the causes and on the date stated above.													
22a. SIGNATURE Thomas F. Crahan		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		4/26/62		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M. D.		22d. ADDRESS VAH, FT. HOWARD, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-31-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat		23d. LOCATION (City, town or county) Baltimore md (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Chas C. Wilson				ADDRESS 1005 Southy Ave		25a. REC'D BY REGISTRAR MAY 1 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

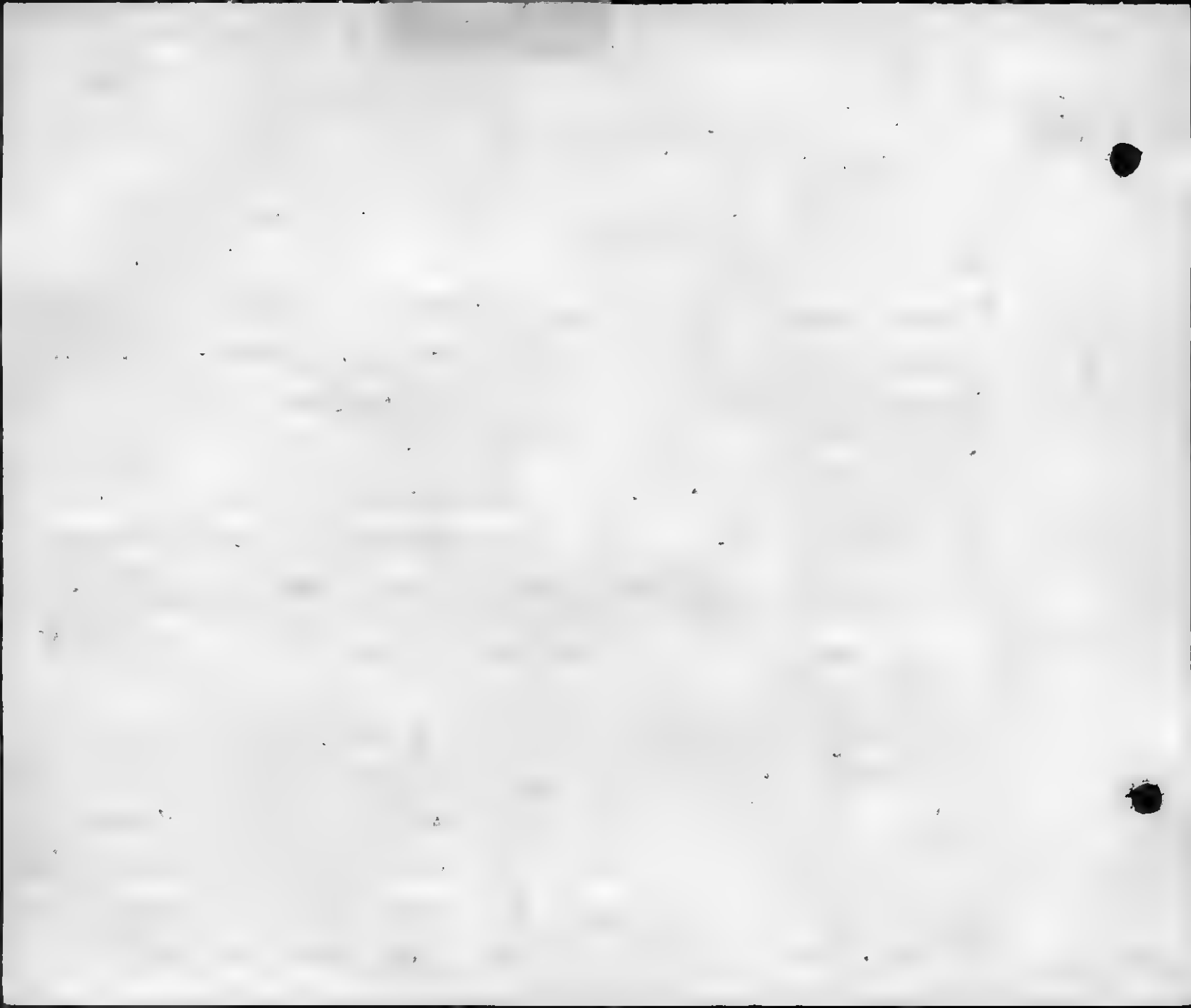
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04184

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Locheysville</u> c. LENGTH OF STAY IN <u>MD.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>greentop Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>1618 Northbourne Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Carr</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>19 FEB 08</u> 9. AGE (In years last birthday) <u>54</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MASSACHUSETTS USA BIRTH</u> 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? <u>USA BIRTH</u>		4. DATE OF DEATH <u>April 21st. 19 62</u> 13. FATHER'S NAME <u>JOSEPH MENDO</u> 14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>178187850</u> 17. INFORMANT <u>HUSBAND</u> Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> DUE TO (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>(R) ADENOCARCINOMA - BREAST</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>4/19/62</u> to <u>4/19/62</u>, that (1) (we) last saw the deceased alive on <u>4/19/62</u>, and that death occurred <u>4/21/62</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Donald O. Wood</u> 22b. DATE SIGNED <u>4/21/62</u> 22c. PHYSICIAN'S NAME (Type) <u>Donald O. Wood</u> 22d. ADDRESS <u>YORK RD & GREENWADOW PK MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/24/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem.</u> 23d. LOCATION (City, town or county) <u>BALTIMORE MD.</u> 25a. REC'D BY REGISTRAR <u>APR 30 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thacker</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc</u> ADDRESS <u>5305 Harford Road</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

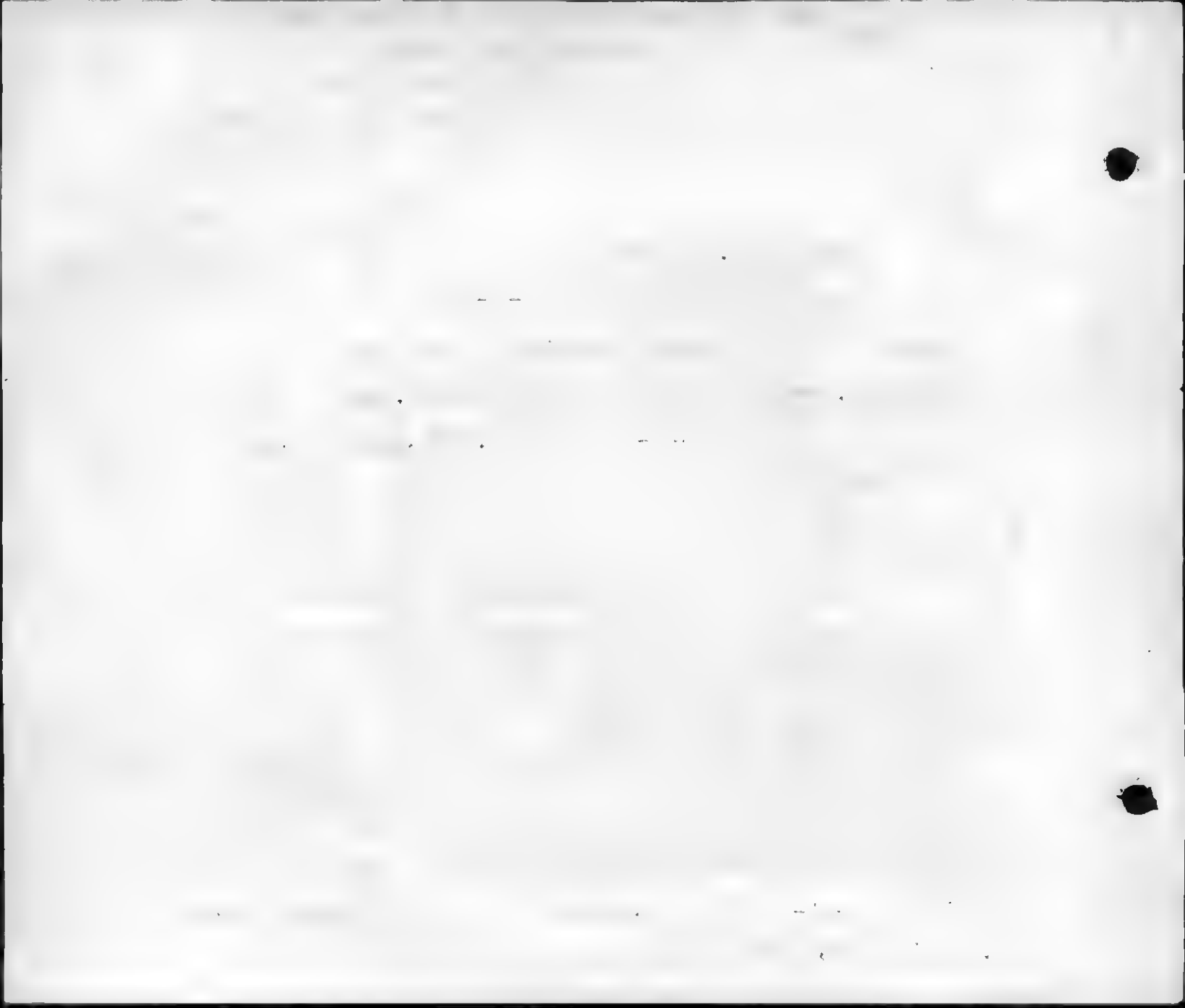
04188

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04185

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grays		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grays	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle C. Last CAVEY		4. DATE OF DEATH Month April Day 24 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gas and Electric	
11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles A. Cavey		14. MOTHER'S MAIDEN NAME Mary A. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-5689	
17. INFORMANT Paul M. Cavey, River Road, Grays Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery arteriosclerosis DUE TO arteriosclerosis, general; with associated myocardial insufficiency and arrhythmia fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 3 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1961 , to April 24, 1962 , that I last saw the deceased alive on April 23, 1962 , and that death occurred at 4:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ellicott City, Md April 24-62			
ACTUAL SIGNATURE Robert B. Taylor		M.D. Ellicott City, Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-27-62	22c. NAME OF CEMETERY OR CREMATORY St. Johns	22d. LOCATION (City, town, or county) (State) Ellicott City, Md
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE APR 26 '62	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 11 & 14, please call Wilson F.H.

6/8/62

04186

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>		c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DENT NURSING HOME</u>		d. STREET ADDRESS <u>939 W. Broadway</u>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Chapman</u> Last <u>Chapman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1885</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u>	IF UNDER 24 HRS. Hours <u>77</u> Min. <u>77</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Junk Collector</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Danville, Va.</u>	
13. FATHER'S NAME <u>Mastan Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>212-01-8953</u>		17. INFORMANT Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>3/17</u> 19 <u>62</u> to <u>4/9</u> 19 <u>62</u> that (H) (we) last saw the deceased alive on <u>4/9</u> 19 <u>62</u> , and that death occurred at <u>11:50 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>4/9/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN E. STROBEL</u>		22d. ADDRESS <u>REISTERSTOWN MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/14/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY CRM.</u>	23d. LOCATION (City, town or county) (State) <u>Brooklyn, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>E.O. Wilson</u>		25a. REC'D BY REGISTRAR DATE <u>4/25/62</u>	
ADDRESS <u>1000 Bently Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>William P. Thomas</u>	

MEDICAL CERTIFICATION



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04187

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>altimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>329 Back River Neck Road</u>		d. STREET ADDRESS <u>1329 Back River Neck Road</u>	
3. NAME OF DECEASED (Type or print) <u>Subie (Susan) Cheatham</u>		4. DATE OF DEATH <u>April 6 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Chauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1898</u>
9. AGE (If years; If UNDER 1 YEAR, If UNDER 24 HRS. last birthday) Months Days Hours Min. <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Richard Andrews</u>	
14. MOTHER'S MAIDEN NAME <u>Susan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Cheatham</u> Address <u>329 Back River Neck Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>+ 20.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u>Arterio-Sclerosis</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u> <u>10 years</u> <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1961</u> to <u>April 6, 1962</u> , that (I) (we) last saw the deceased alive on <u>Apr. 5, 1962</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Morris G. Jacobs</u>		22b. DATE SIGNED <u>4/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris A. Jacobs M.D.</u>		22d. ADDRESS <u>1010 NORTH Point Rd. Balt 24 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>April 8/62</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <u>Mecherren Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Milton E. Ellickson</u>		25a. REC'D BY REGISTRAR <u>APR 11 '62</u>	
25b. REGISTRAR'S SIGNATURE			



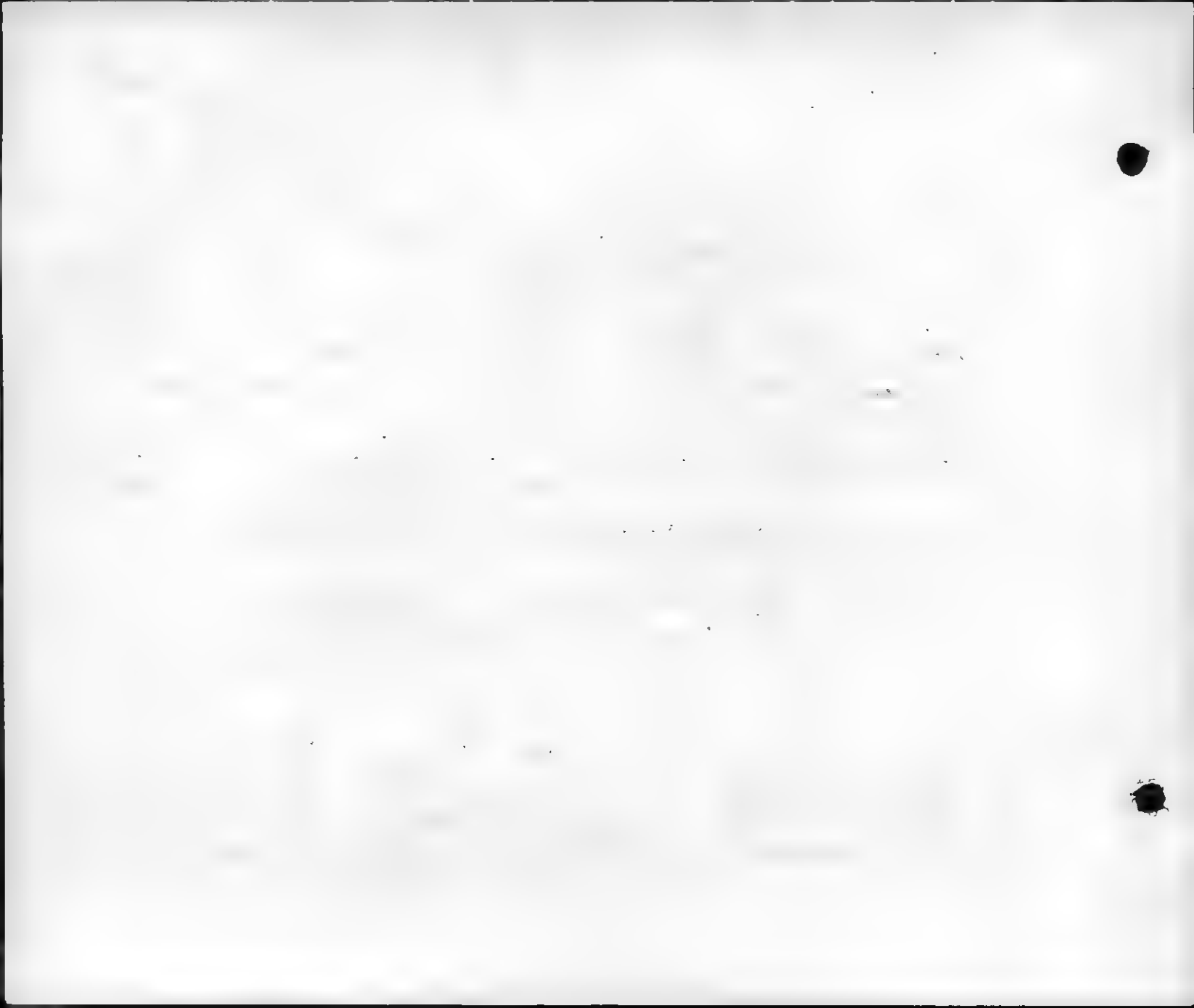
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04191

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04188

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	
c. LENGTH OF STAY IN IB <i>30 years</i>		d. STREET ADDRESS <i>1425 Bellona ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1425 Bellona ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Irune Gertrude Burton Cockey</i>		4. DATE OF DEATH <i>April 6 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4 July 1888</i>
9. AGE (In years last b. day) <i>73</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Edwardsville, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Burton</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Bee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>—</i>	
17. INFORMANT <i>Sons - Wilson</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO (b) <i>Cerebral and Generalized Arteriosclerosis</i> DUE TO (c) <i>19 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>December 1961</i> to <i>April 1962</i> , that (I) (we) last saw the deceased alive on <i>3 April 1962</i> , and that death occurred at <i>9:18 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter T. Kees</i>		22b. DATE SIGNED <i>6 April 1962</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		22d. ADDRESS <i>Cockeysville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4/10/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem PK.</i>	23d. LOCATION (City, town, or county) (State) <i>Balt. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Chatman Jr.</i>		25a. REC'D BY REG. STRAR <i>APR 10 '62</i>	
ADDRESS <i>1701 Mt. Calvert St. Balt. Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

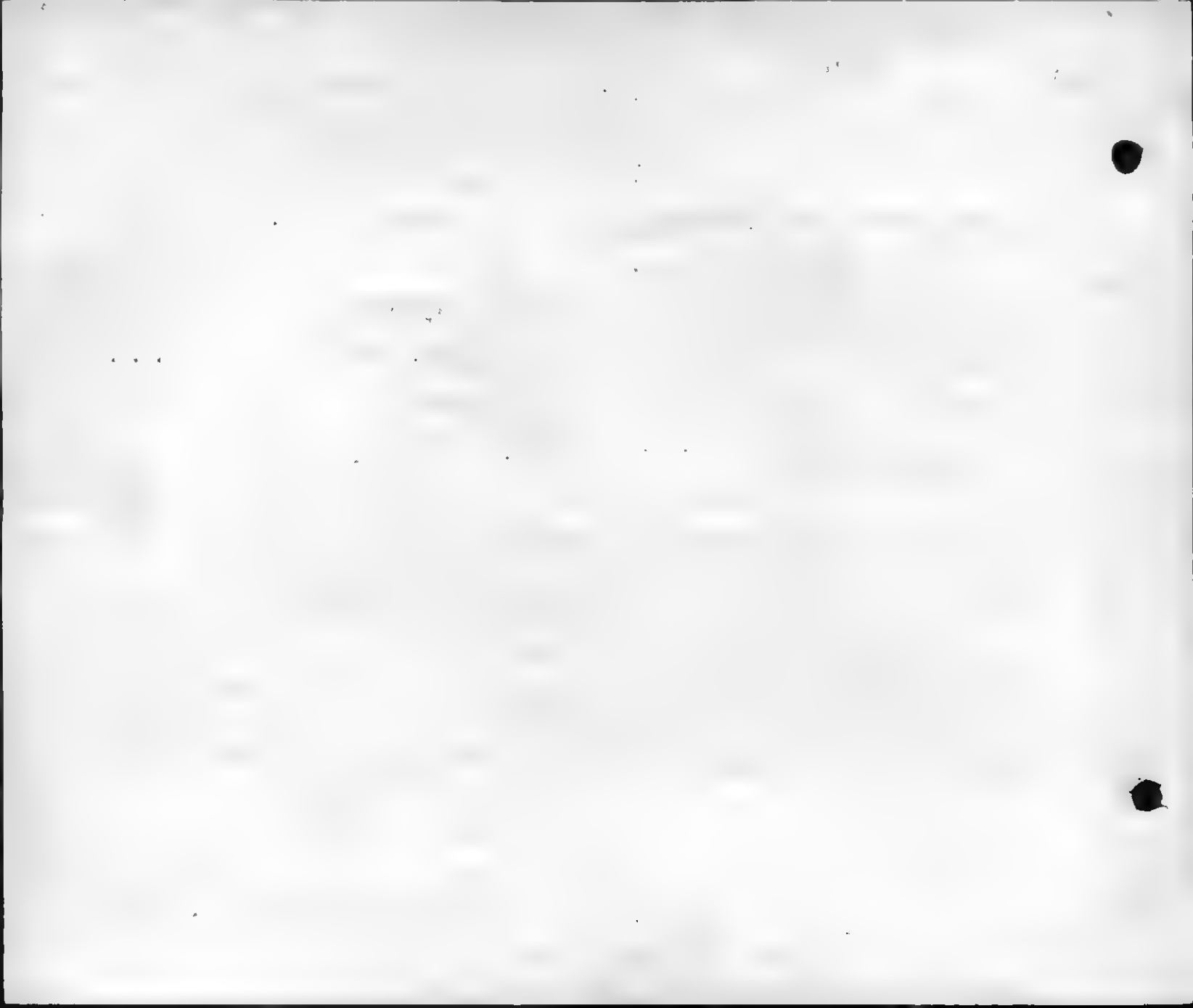
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04192

04189

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN IT 2 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 17 d. STREET ADDRESS 2000 BOLTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY J. COLE First Middle Last		4. DATE OF DEATH APRIL 27 19 62 Month Day Year	
5. SEX MALE 6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH September 1, 1893 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 68 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cole		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 219-01-1141	
17. INFORMANT CLINICAL RECORDS VAH, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) BRONCHOPNEUMONIA DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF STOMACH DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 24 Hours 18 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that D (this hospital) attended the deceased from 25 April 1962 to 27 April 1962 that we last saw the deceased alive on 27 April 1962 and that death occurred at 11:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Arthur J. Smith		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy C. Wilson		25a. REC'D BY REGISTRAR DATE MAY 1 '62	
1000 ADDRESS Bonity Ave		25b. REGISTRAR'S SIGNATURE Arthur J. Smith	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

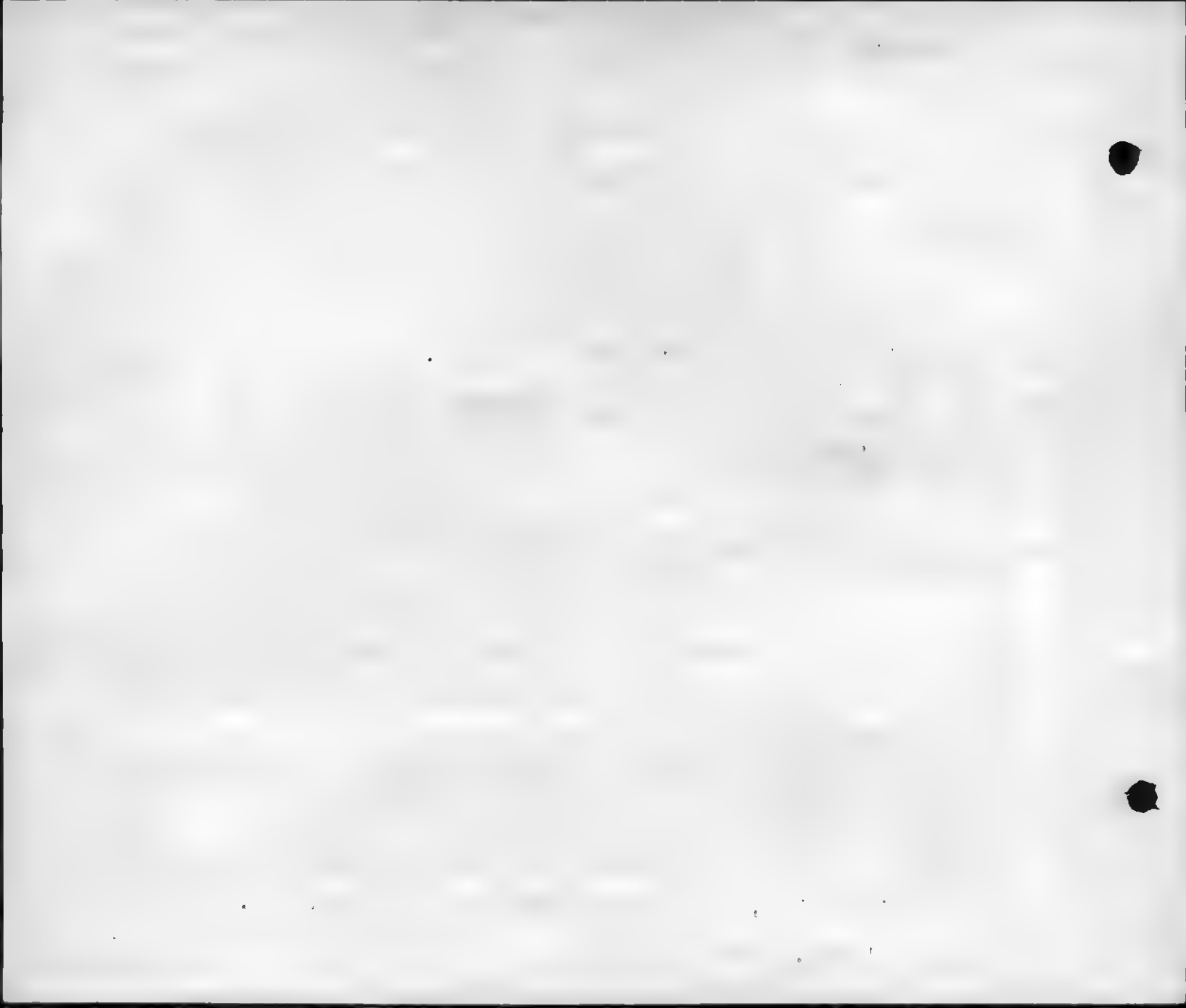
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04190

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>BALTIMORE</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u></p> <p>c. LENGTH OF STAY IN 1b <u>6 HRS</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>113 SHETLAND HILLS DRIVE</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission)</p> <p>a. STATE <u>MASS.</u> b. COUNTY <u>ATHOL</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ATHOL</u></p> <p>d. STREET ADDRESS <u>32 OLIVER ST</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>MARY CATHERINE COLTON</u></p> <p>5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-18-92</u></p> <p>9. AGE (In years last birthday) <u>69</u> yrs. 10. FUND 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.</p>		<p>4. DATE OF DEATH <u>APRIL 9 1962</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>Mass.</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>Mass.</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>ROBERT GLASHEEN</u></p> <p>14. MOTHER'S M A D E N NAME <u>Josephine DOOLAN</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOC AL SECURITY NO. <u>None</u></p>	
<p>17. INFORMANT <u>MRS. MARY MACIACIUS, Daughter, 113 SHETLAND HILLS DR</u></p> <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I DEATH WAS CAUSED BY: <u>CEREBRO-VASCULAR ACCIDENT</u></p> <p>IMMEDIATE CAUSE (a) <u>3-51X</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO</p> <p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>INTERVAL BETWEEN ONSET AND DEATH 1 MIN</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		<p>20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <u>William A. Pillsbury</u></p> <p>EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>Address (Street, city, town, or county) <u>110 W. Main, BALTO. MD.</u></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u></p> <p>22b. DATE THEREOF <u>April 9, 1962</u></p> <p>22c. NAME OF CEMETERY OR CREMATORY <u>Murphy Funeral Home</u></p> <p>22d. LOCATION (City, town, or country) (State) <u>Athol, Mass.</u></p>		<p>23. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> ADDRESS</p> <p>24a. REC'D BY REGISTRAR <u>DATE APR 11 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u></p>	

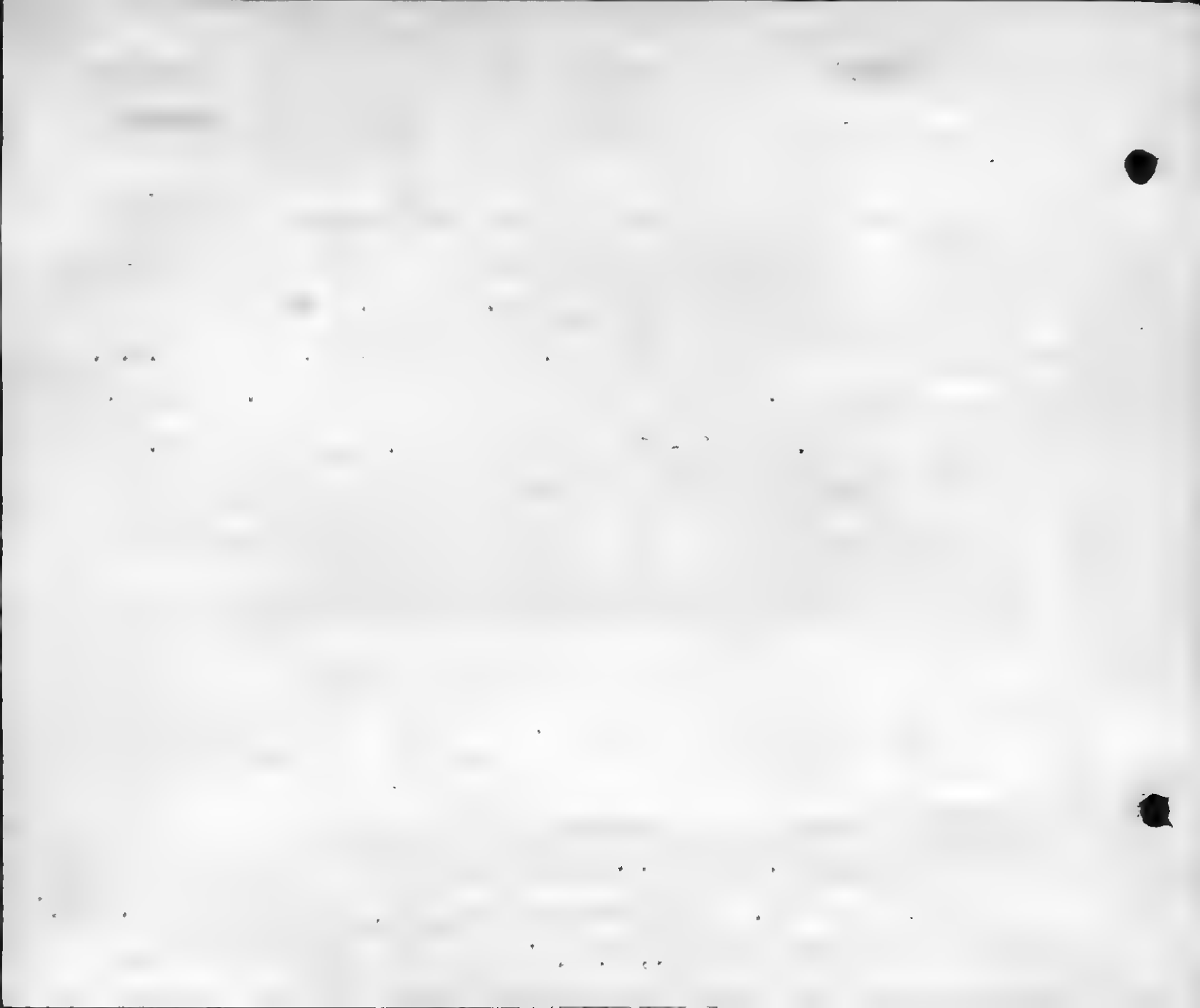


1
FOR STATE,
HEALTH DEPT.
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND

04194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04191

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN lb MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) American Oil Station		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY [REDACTED] c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore #24, d. STREET ADDRESS 1309 DeMarcy Way (O'Donnell Hgts.)			
3. NAME OF DECEASED (Type or print) FREDERICK AMBROSE CONRAD		4. DATE OF DEATH April 16, 1962		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 15, 1921.		9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 4 Days 16 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gas Station.		11. BIRTHPLACE (State or foreign country) Cresson, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter A. Conrad		14. MOTHER'S MAIDEN NAME Gertrude T. Switzler.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 184-16-5344		17. INFORMANT Gertrude T. Conrad Address Same.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of brain. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by unknown assailant during holdup 20c. TIME OF INJURY Month, Day, Year 4/16/ 1962 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office b'dg., etc.) Amer. Oil Station 20f. (City or town) (County) (State) Baltimore, Maryland					
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/62 Address (Street, city, town, or county) _____					
ACTUAL SIGNATURE Russell S. Fisher M.D.		EXAMINER'S NAME (Type) Russell S. Fisher, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-62.		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
22d. LOCATION (City, town, or country) Balto.		23. FUNERAL DIRECTOR Charles S. Zeiler		24a. REC'D BY REGISTRAR APR 19 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kram		24c. ADDRESS 6224 Eastern Ave. Balto., 24, Md.			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04195

04192

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
c. LENGTH OF STAY IN 1b <u>55 Days</u>		d. STREET ADDRESS <u>1633 McCulloh Street</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JOHN I COOK</u>		4. DATE OF DEATH <u>April 16 19 62</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-11</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>	9. AGE (In years last birthday) <u>50</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months	Days						
11. BIRTHPLACE (County & State, or foreign country) <u>Allegheny County Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Cook</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Hill</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>217-09-7321</u>					
17. INFORMANT <u>Clin Rec VAH Fort Howard Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>4-9-62</u> (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Squamous Cell Carcinoma, Right Lung</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb 20 1962</u> , to <u>April 16 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 16 1962</u> , and that death occurred at <u>5:30 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Irving Freeman</u>		22b. DATE SIGNED <u>4/17/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, MD, Chief, Medical Service VAH Ft Howard, Md</u>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>William I. Chatman Jr.</u>		25a. REC'D BY REGISTRAR <u>APR 18 '62</u>					
ADDRESS <u>1701 McCulloh St Balto Md</u>		25b. REGISTRAR'S SIGNATURE <u>William I. Chatman Jr.</u>					



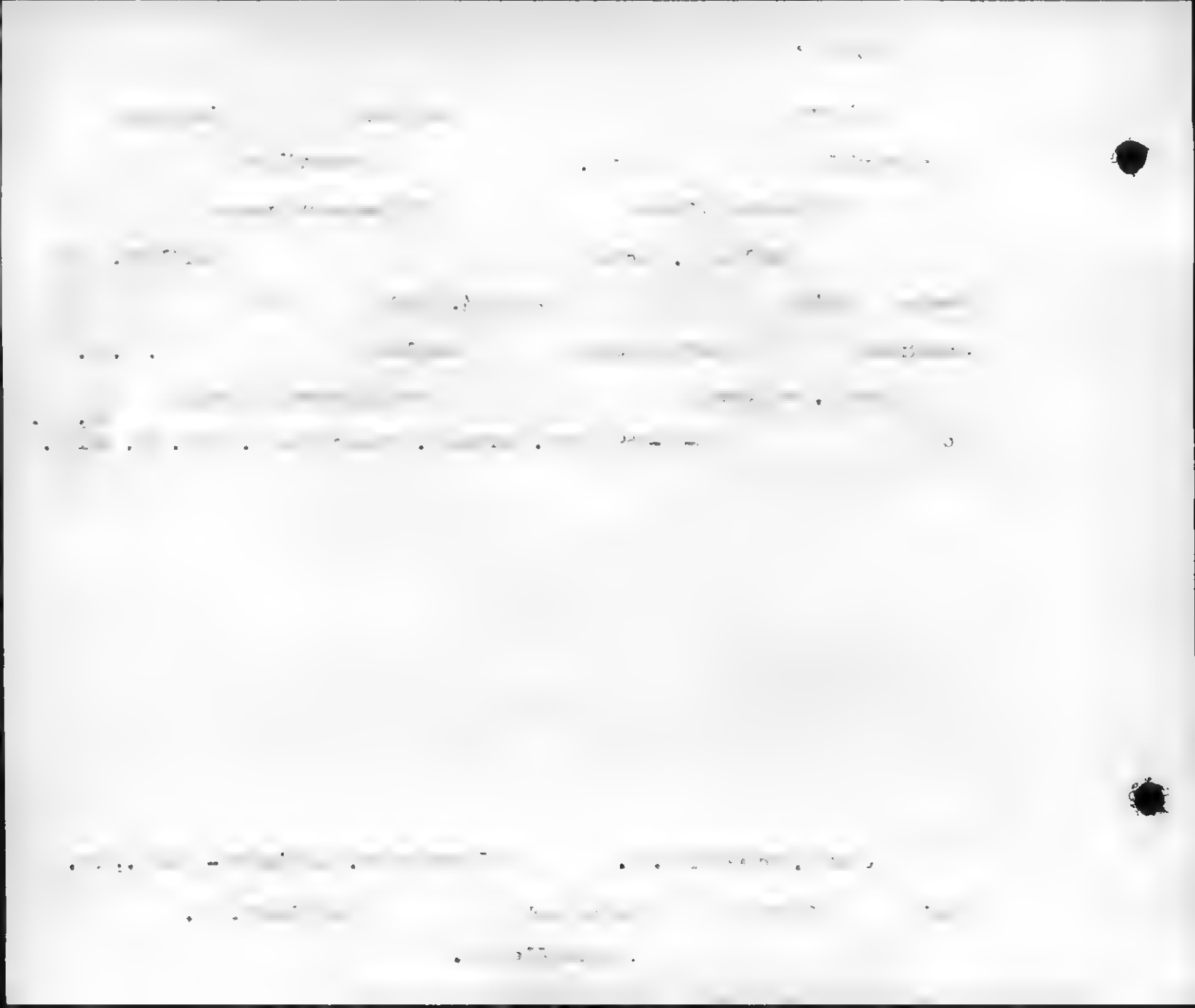
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
04196
MAY 1962
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04193

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN 1b 54 yrs.		d. STREET ADDRESS 232 Beaumont Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Beaumont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie E. Cooke		4. DATE OF DEATH April 30, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1879
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John R. Mc Comas		14. MOTHER'S MAIDEN NAME Mary Elizabeth Gosnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-3592	
17. INFORMANT Mrs. Bertha M. Fraser		Address 1114 E. 30th, St. Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO HYPERTENSIVE CV DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 18 HOURS 2 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 4, 1961 to APR. 30, 1962 , that (I) (we) last saw the deceased alive on APR. 29, 1962 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John F. Schaefer		22b. DATE SIGNED MAY 2, 1962	
22c. PHYSICIAN'S NAME (Type) John F. Schaefer M. D.		22d. ADDRESS 401 Random Rd. Baltimore - Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/1962	
23c. NAME OF CEMETERY OR CREMATORY Louder Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04197

CERTIFICATE OF DEATH

Reg. Dist. No. 01134

1 PLACE OF DEATH a. COUNTY <i>Baltimore - 19 -</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD. AS</i> b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X NW SPARROWS PT.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2914 Sparrows Pt. Rd</i>		d. STREET ADDRESS <i>2914 SPARROWS PT. RD.</i>	
3 NAME OF DECEASED (Type or print) <i>Charlotte May Cousins</i>		4. DATE OF DEATH Month <i>APR.</i> Day <i>20</i> Year <i>1962</i>	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1898</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shirt</i>	
11 BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Alexander De Vaughn</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Frances Frey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO. <i>212-038523</i>	
17 INFORMANT <i>Emma Mack</i>		Address <i>P.O. Balto 19-Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>113 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>5 years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 28, 1960</i> to <i>Apr 20, 1962</i> that I last saw the deceased alive on <i>April 12, 1962</i> and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Torkin</i> M.D.		ADDRESS (Street, city or town, state) <i>6408 N. Pt. Rd. Balto 19-Md</i>	
PHYSICIAN'S NAME (Type) <i>LOUIS N. TORKIN</i>		DATE SIGNED <i>4/20/62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>APR 23, 1962</i>	22c. NAME OF CEMETERY OR CREMATORY <i>BALTO. NATIONAL</i>	22d. LOCATION (City, town, or county) (State) <i>BALTO. CO. MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hoffmann</i>		ADDRESS <i>3218 HUDSON ST.</i>	
24a. REC'D BY REGISTRAR <i>APR 23 1962</i>		24b. REGISTRAR'S SIGNATURE <i>W. S. Hume</i>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04198

04195

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> c. LENGTH OF STAY IN <u>8 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> d. STREET ADDRESS <u>York Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Elva P. Cox</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24 1892</u>
9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Tools</u> 11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Heaps</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMATION <u>Mr. Eugene Miller, Parkton, Md. R.D.</u>		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular disease</u> DUE TO (c)	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <u>1957</u> to <u>April 22, 1962</u> that (I) (we) last saw the deceased alive on <u>April 22, 1962</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u> M.D.		22b. DATE SIGNED <u>4/22/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE, THEREOF <u>April 25, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>New Freedom, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>DATE APR 24 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>			

(M)

(I)



TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04199

04196

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN 1b 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 East Ship Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Eason Last Cox		4. DATE OF DEATH Month April Day 8 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 4 Days 5 Hours 15 Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Eason		14. MOTHER'S MAIDEN NAME Eliza Stephens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, no known) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Louis T. Cox, 1 East Ship Road, Dundalk 22, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-5/1962		INTERVAL BETWEEN ONSET AND DEATH 4-5/1962	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Stroke	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dundalk 22, Md	
21. I certify that (I) (this hospital) attended the deceased from April 8, 1962 that (I) (we) last saw the deceased alive on April 7, 1962 and that death occurred on April 8, 1962 from the causes and on the date stated above.			
22a. SIGNATURE Melvin B. Davis, M.D.		22b. DATE SIGNED 4-9/62	
22c. PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D.		22d. ADDRESS 6800 Morningson Road, Dundalk 22, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 4-10-62	
23c. NAME OF CEMETERY OR CREMATORY Eason Cemetery		23d. LOCATION (City, town, or county) (State) South Mills, North Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2		25a. REC'D BY REGISTRAR APR 11 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]		25c. DATE APR 11 '62	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

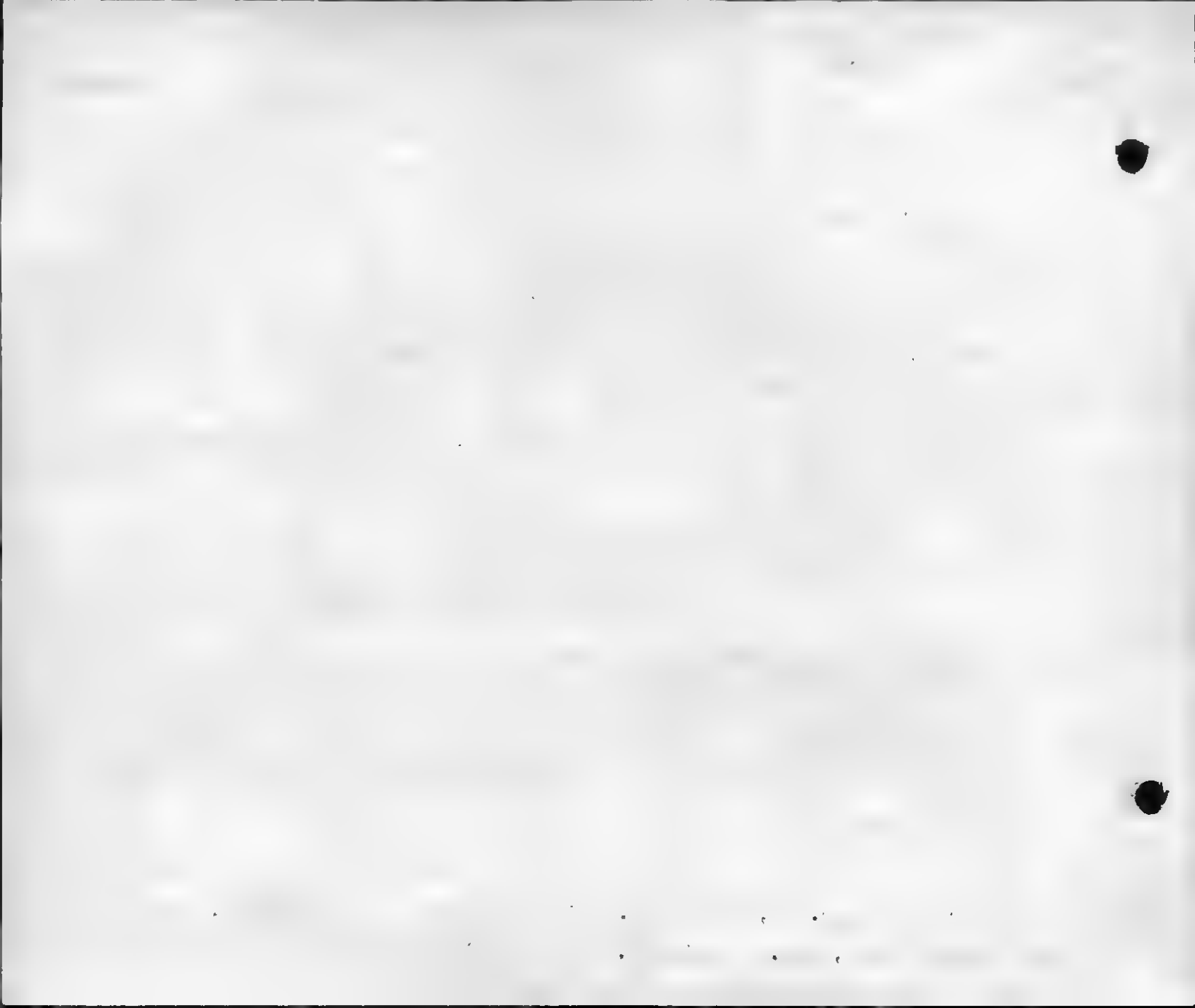
CERTIFICATE OF DEATH

04200

04197

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeysville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>2872 Hanford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u> Md. Masonic Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Crawford</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Huber</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gorman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Masonic Home Records - Cockeysville, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1961</u> to <u>April 1962</u> , that (I) (we) last saw the deceased alive on <u>April 20, 1962</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Sherrill</u>		22b. DATE SIGNED <u>4/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill MD</u>		22d. ADDRESS <u>Cockeysville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 24 '62</u>	
ADDRESS <u>1217 St. Paul Street</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thoma</u>	

VR A15 (4)
15M 9/60



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

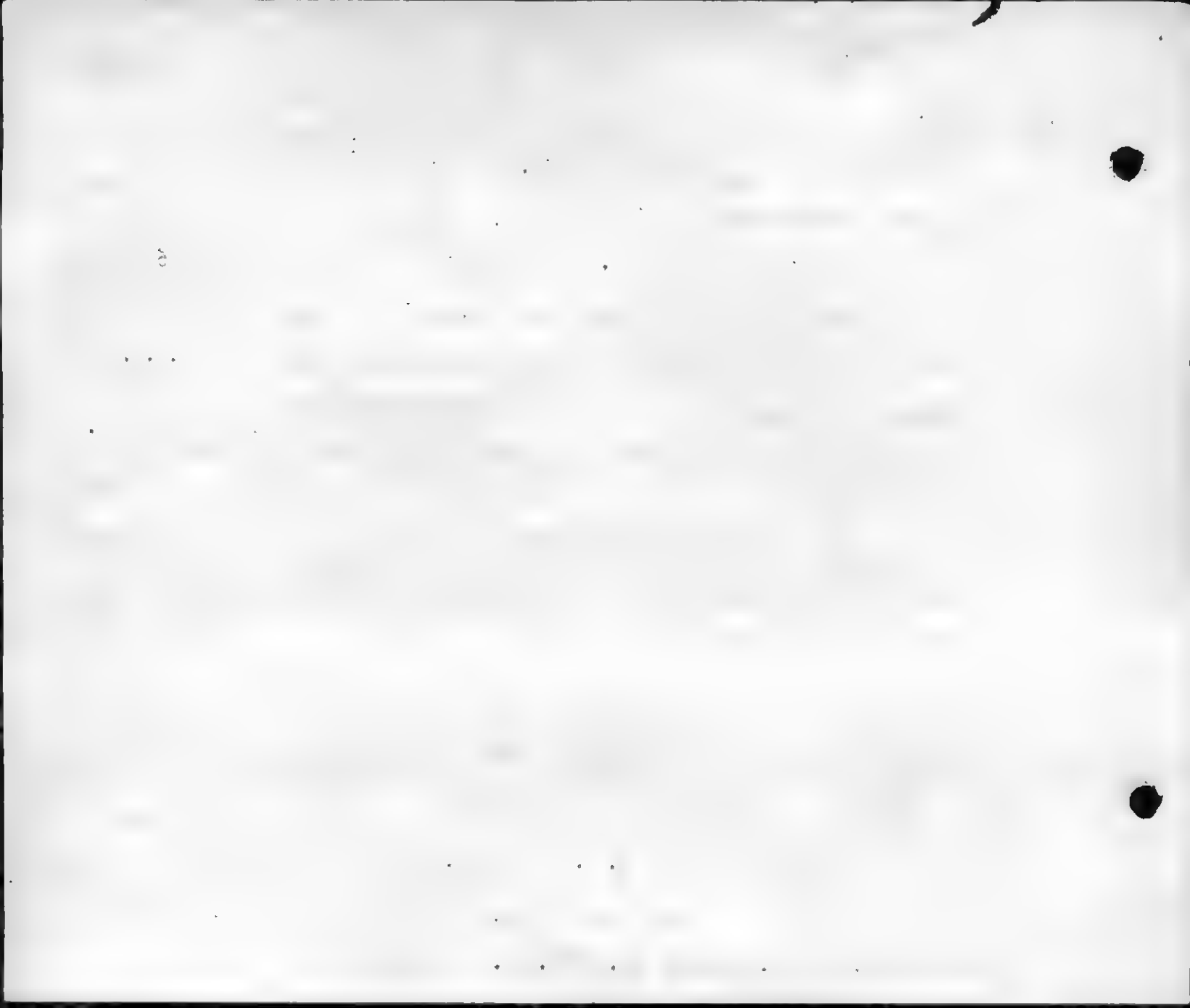
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1

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04201									
04198									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN It 2 Hours 35 Min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 11437 Mulliken Court				
3. NAME OF DECEASED (Type or print) James P. JERNELL Cromwell					4. DATE OF DEATH Month April Day 6 Year 1962				
5. SEX Male					6. COLOR OR RACE Negro				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH July 5, 1913				
9. AGE (In years last birthday) 48 yrs					10. IF UNDER 1 YEAR Months 4 Days 6				
11. IF UNDER 24 HRS. Hours 2 M'n 35					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Paper Box Factory				
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James Cromwell					14. MOTHER'S MAIDEN NAME Lula Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII					16. SOCIAL SECURITY NO. 219-05-5309				
17. INFORMANT Clinical Records, Veterans Adm. Hospital, Fort Howard, Maryland					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGIC PANCREATITIS 501.6 DUE TO Conditions, if any, which gave rise to immediate cause (b) CIRRHOSIS OF LIVER (c), stating the underlying cause last. DUE TO (c) UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RIGHT LOWER LOBE PNEUMONIA									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 5, 1962 to April 6, 1962 , that (I) (we) last saw the deceased alive on April 6, 1962 , and that death occurred at 2:20 A.M. from the causes and on the date stated above									
22a. SIGNATURE Sebastian Russo					22b. DATE SIGNED 4/6/62				
22c. PHYSICIAN'S NAME (Type) S. SEBASTIAN RUSSO, M. D.					22d. ADDRESS VAH, FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 4-10-62				
23c. NAME OF CEMETERY OR CREMATORY Baltimore National					23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Locks					25a. REC'D BY REGISTRAR APR 10 '62				
25b. REGISTRAR'S SIGNATURE Joseph Locks					25c. REGISTRAR'S SIGNATURE Joseph Locks				



TO HOSPITAL OR FUNERAL DIRECTOR: This low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

04202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04199

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 yrs. 11 mo. 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIDGEWAY MANOR</u>				d. STREET ADDRESS <u>803 WILLOWOOD PKWY.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LYDIA BURTON CROSS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 21 1962</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CECIL CO., MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ORLANDO BURTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN MUMFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MALCOLM J. COAN</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory failure</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>left side hemiplegia</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized & severe</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1960</u> to <u>21 April, 1962</u> that (I) (we) last saw the deceased alive on <u>21 April, 1962</u> and that death occurred at <u>2:10 pm</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>William J. Bryson MD</u>				22b. DATE SIGNED		22c. ADDRESS <u>4105 Edmonday Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		23d. LOCATION (City, town, or county) (State) <u>LAUREL, DELAWARE</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN O. MITCHELL & SONS, INC.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

(I)

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04203

04200

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

STATE
Maryland

COUNTY
Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

d. STREET ADDRESS

8623 Chestnut Oak Avenue, Balto. 34

8623 Chestnut Oak Avenue 34

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

EDNA

Clark

CROW

4. DATE OF DEATH

Month

Day

Year

4

23

1962

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female

White

WIDOWED ☒

DIVORCED ☐

July 25, 1905

56 yrs.

Months Days

Hours M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired Homemaker

Baltimore, Maryland

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

John Butt

Elizabeth Hammel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

Mr. William R. Burns-5713 Gwynn Oak Avenue #7

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Cirrhosis of liver

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

Address (Street, city, town, or county)

4-23-62

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

Burial

4-26-62

Loudon Park Cemetery

Baltimore, Maryland

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Wm J. Tucker & Sons

Balto 17, Md.

DATE APR 24 '62

Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



04204

CERTIFICATE OF DEATH

Reg. Dis. 04201

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Rosedale</u>		c LENGTH OF STAY IN 1b <u>x RURAL - Rosedale</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8304 Philadelphia Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>William</u> Last <u>CRUSSE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 16, 1899.</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Charles B. CRUSSE</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Sweeney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-1692</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>April 18, 1962</u> to <u>April 18, 1962</u> , that I last saw the deceased alive on <u>April 18, 1962</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.		DATE SIGNED <u>4/19/62</u>	
ACTUAL SIGNATURE <u>John H. Orth</u>		ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd</u>	
PHYSICIAN'S NAME (Type) <u> </u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-21-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Couch</u>		ADDRESS <u>1211 Cheseco Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

Page 4

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04205

04202

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN <u>1b</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armacost Nursing Home-812 Regester Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission). a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2301 Kenoak Road #9</u>	
3. NAME OF DECEASED (Type or print) <u>Edna Dalsemer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 1. 1880</u>	9. AGE (in years last birthday) <u>81 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <u>Philadelphia, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Dalsemer</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Greenwald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Gordon H. Dalsemer-2301 Kenoak Road #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pemphigus</u> DUE TO cause last, (c) <u>-</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Arteriosclerotic Cerebrovascular Disease</u>	
20a. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20d. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that (I) (the hospital) attended the deceased from <u>10/15</u> 19<u>52</u> to <u>4/4</u> 19<u>62</u> that (I) (the) last saw the deceased alive on <u>4/4</u> 19<u>62</u> and that death occurred at <u>4:20AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Elliot Levi</u>		22b. DATE SIGNED <u>4/4</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>J. ELLIOT LEVI</u>		22d. ADDRESS <u>222 W. COLD SPRING LANE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-18-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Hebrew Congregation</u>		23d. LOCATION (City, town or county) <u>BALTO 10, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Schaefer</u>		25a. REC'D BY REGISTRAR <u>APR 18 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>Balto 12, Maryland</u>	



TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

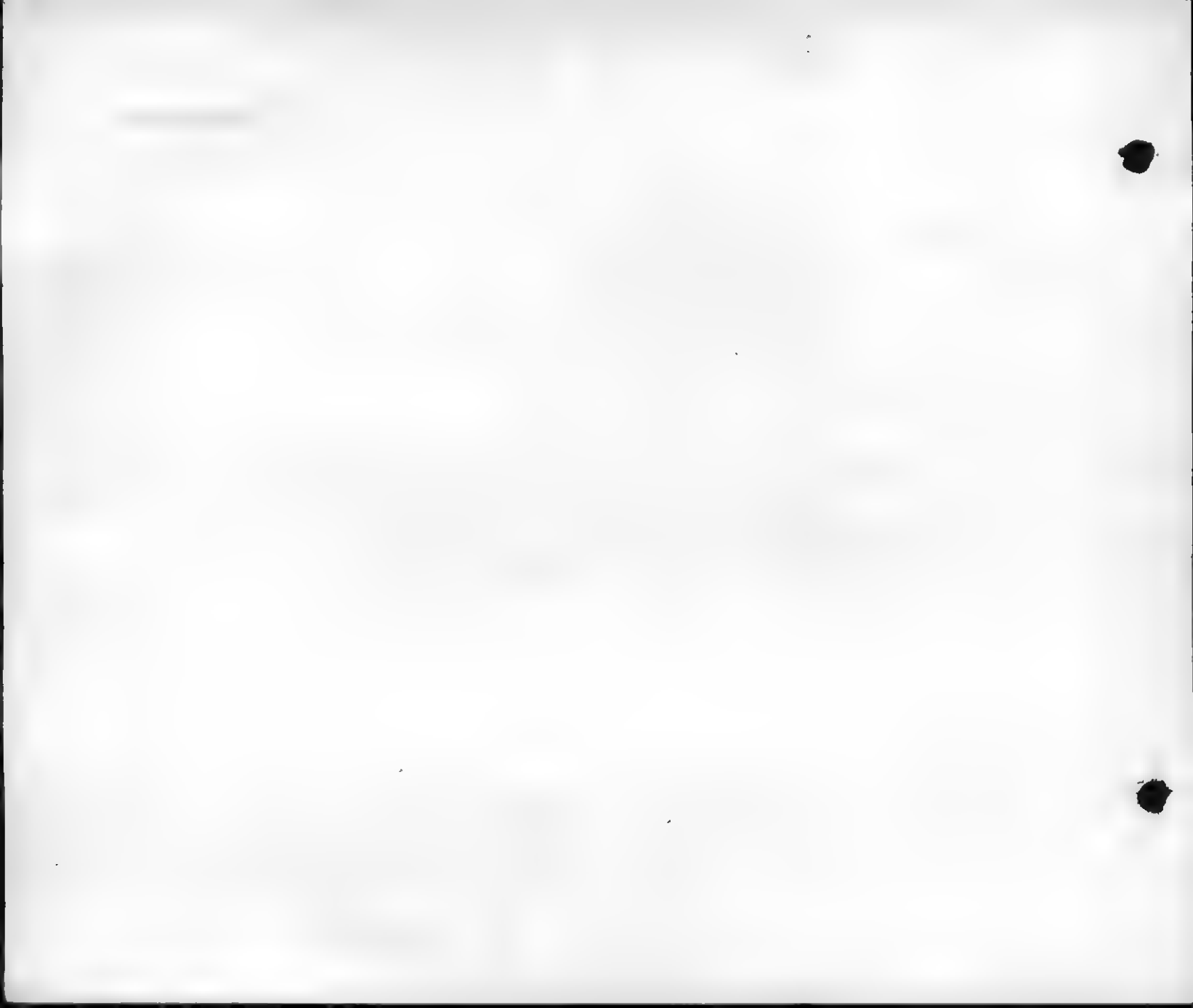
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04206

04203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (RURAL)				c. LENGTH OF STAY IN 1b 74 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHEPPARD YENOCK PRATT HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HELEN LOUISE DAVIS				4. DATE OF DEATH Month Day Year APRIL 4 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 5, 1887	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER-RETIRED				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME HOWARD DAVIS				14. MOTHER'S MAIDEN NAME Ida Welden WELDEN-IDA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address HOSPITAL CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 24 1961 to April 4 1962 , that (I) (we) last saw the deceased alive on April 4 1962 , and that death occurred at 24M , from the causes and on the date stated above.							
22a. SIGNATURE W.W. Elgin		M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M.D.		22d. ADDRESS Sheppard Pratt Hosp. Towson, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-7-62		23c. NAME OF CEMETERY OR CREMATORY Friends Burial Ground		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Schenck Baltimore, Md.				25a. REC'D BY REGISTRAR DATE APR 5 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	



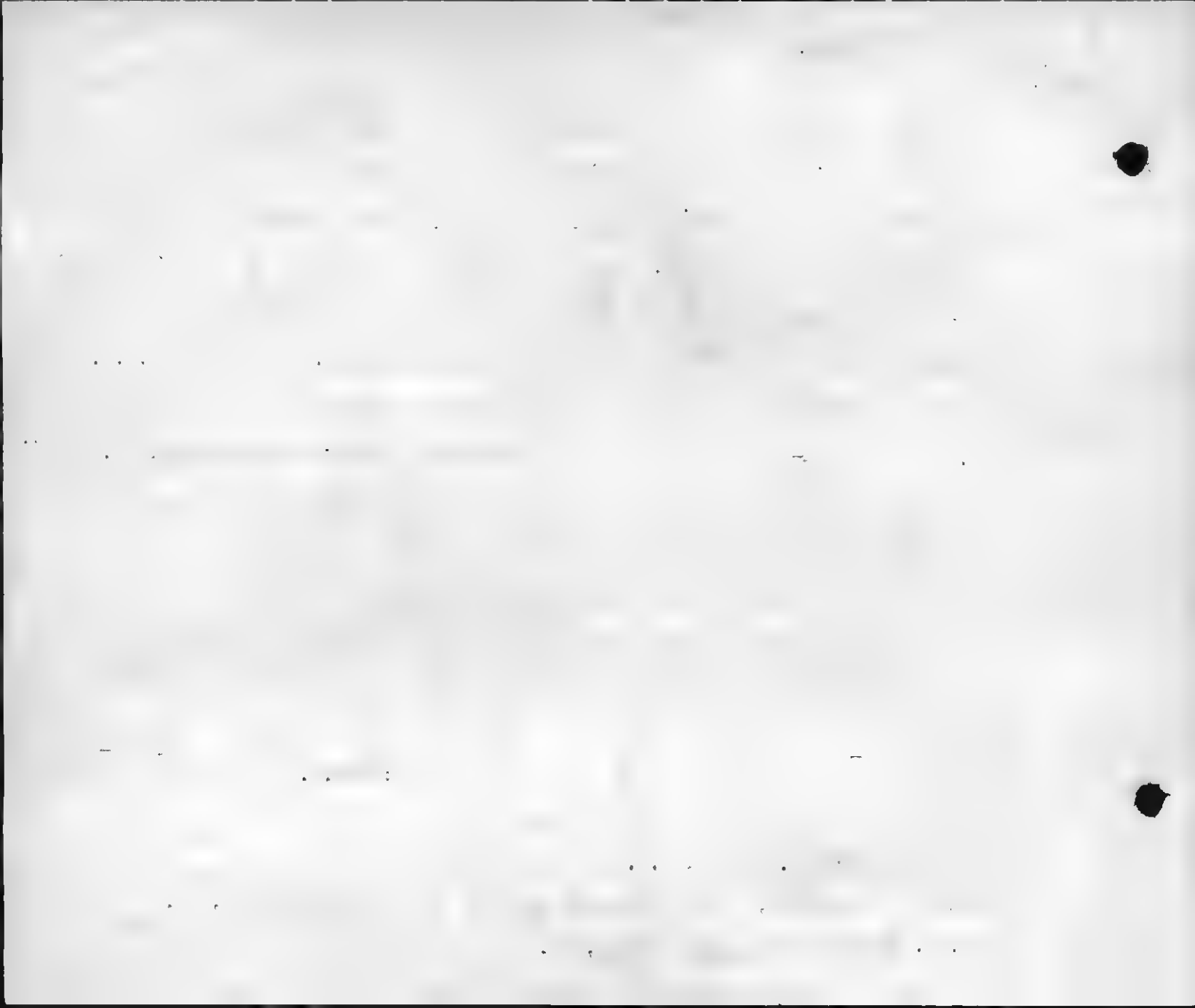
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TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04202
04204

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		b. COUNTY <u>Baltimore 2</u>	
c. LENGTH OF STAY IN 1b <u>8 months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>1710 Barclay Street</u>	
3. NAME OF DECEASED (Type or print) <u>Randolph, Jr.</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/50</u>	
9. AGE (In years last birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Randolph Deminds</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mae Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Rosewood Records, Owings Mills, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Right side lobar pneumonia with lung abscess.</u> (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spastic quadriplegia with symptomatic Epilepsy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>8 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (4) (this hospital) attended the deceased from <u>7/6</u> , 19 <u>61</u> , to <u>4/3</u> , 19 <u>62</u> , that (1) (we) last saw the deceased alive on <u>4/3</u> , 19 <u>62</u> , and that death occurred at <u>10:20 p.m.</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>Harry G. Butler</u>		22b. DATE SIGNED <u>4/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		22d. ADDRESS <u>Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 9, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Owings Mills, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR DATE <u>APR 11 '62</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04205

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> c. LENGTH OF STAY in 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2027 Skyline Road #4</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> d. STREET ADDRESS <u>2027 Skyline Road #4</u>	
3. NAME OF DECEASED (Type or print) <u>William K. Diehl</u>		4. DATE OF DEATH <u>April 19 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Oct. 4, 1913</u>	9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician-self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York City</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William K. Diehl, Sr.</u>		14. MOTHER'S M.A.D.N. NAME <u>Charlotte Neumer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-36-5276</u>	
17. INFORMANT <u>Mrs. Ann L. Diehl</u>		Address <u>2027 Skyline Rd., Ruxton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Arteriosclerosis CVD</u> (c) <u>Ischemic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischemic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> , 19 <u>45</u> to <u>4/19</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>62</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. J. [Signature]</u>		22b. DATE SIGNED <u>4/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. J. [Signature]</u>		22d. ADDRESS <u>14 E. [Signature] St. Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-23-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. [Signature]</u>		25. REC'D BY REGISTRAR <u>25. REGISTRAR'S SIGNATURE</u>	
DATE <u>APR 23 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

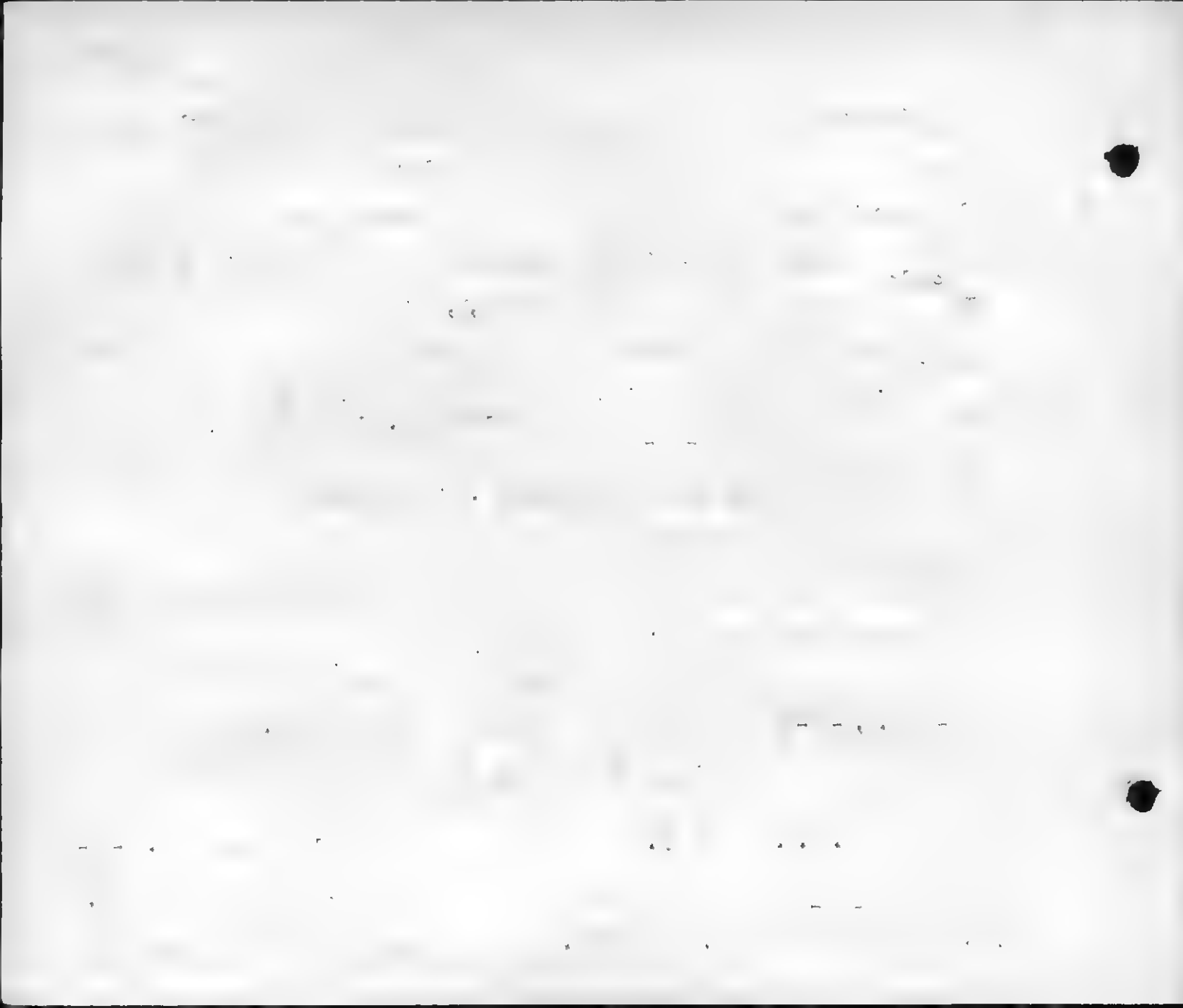


1
FOR STATE
HEALTH DEPT
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

04209
04206
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2148 Lorraine Ave		d. STREET ADDRESS 2148 Lorraine Ave	
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH April 21, 1962	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Mar. 1, 1922	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Willard Candler		14. MOTHER'S MAIDEN NAME Maud. Messer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-14-9362	
17. INFORMANT Paul Doering		18. ADDRESS 2148 Lorraine Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound in chest # 12 Shot Gun DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Shot herself while lying in bed with #12 Shot gun DUE TO (c) Shot herself while lying in her bed with # 12 shot gun evidently pulled trigger with her toes		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot herself while lying in bed with #12 Shot gun		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (In nature of injury, in Part I, or Part I, of item 18.) Shot herself while lying in her bed with # 12 shot gun		20c. TIME OF INJURY Month, Day Year 11-15 P.M. 4-21-62	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodlawn Baltimore Co. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Geo. S.M. Kieffer EXAMINER'S NAME (Type) Geo. S.M. Kieffer M.D.		DATE SIGNED 4-21-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1962	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or country) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,		24a. REC'D BY REGISTRAR APR 24 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



1
FOR STATE
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04207

04210

1. PLACE OF DEATH
a. COUNTY BALTO
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bluesdale
c. LENGTH OF STAY IN MD MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) In front of #5 Kushi Blvd.

2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS NO RECORD

3. NAME OF DECEASED (Type or print) Charles H. Easterday
4. DATE OF DEATH April 17 1962
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 10 1906
9. AGE (in years, last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circulation Distributor
10b. KIND OF BUSINESS OR INDUSTRY MD
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME William H. Easterday
14. MOTHER'S MAIDEN NAME Laura J. Haller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO
16. SOCIAL SECURITY NO. May Lohman 10 Mc Keldin Dr Boonstra
17. INFORMANT May Lohman 10 Mc Keldin Dr Boonstra
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b) A-S-C-V Disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE M.B. Davis M.D.
EXAMINER'S NAME (Type) M.B. Davis M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) 4/19/62
DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4/21/62
22c. NAME OF CEMETERY OR CREMATORY Middleton Cem
22d. LOCATION (City, town, or county) (State) Middleton Md
23. FUNERAL DIRECTOR Best Funeral Home Boonstra ADDRESS
24a. REC'D BY REGISTRAR APR 23 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Kramo



FOR STATE
HEALTH DEPT.

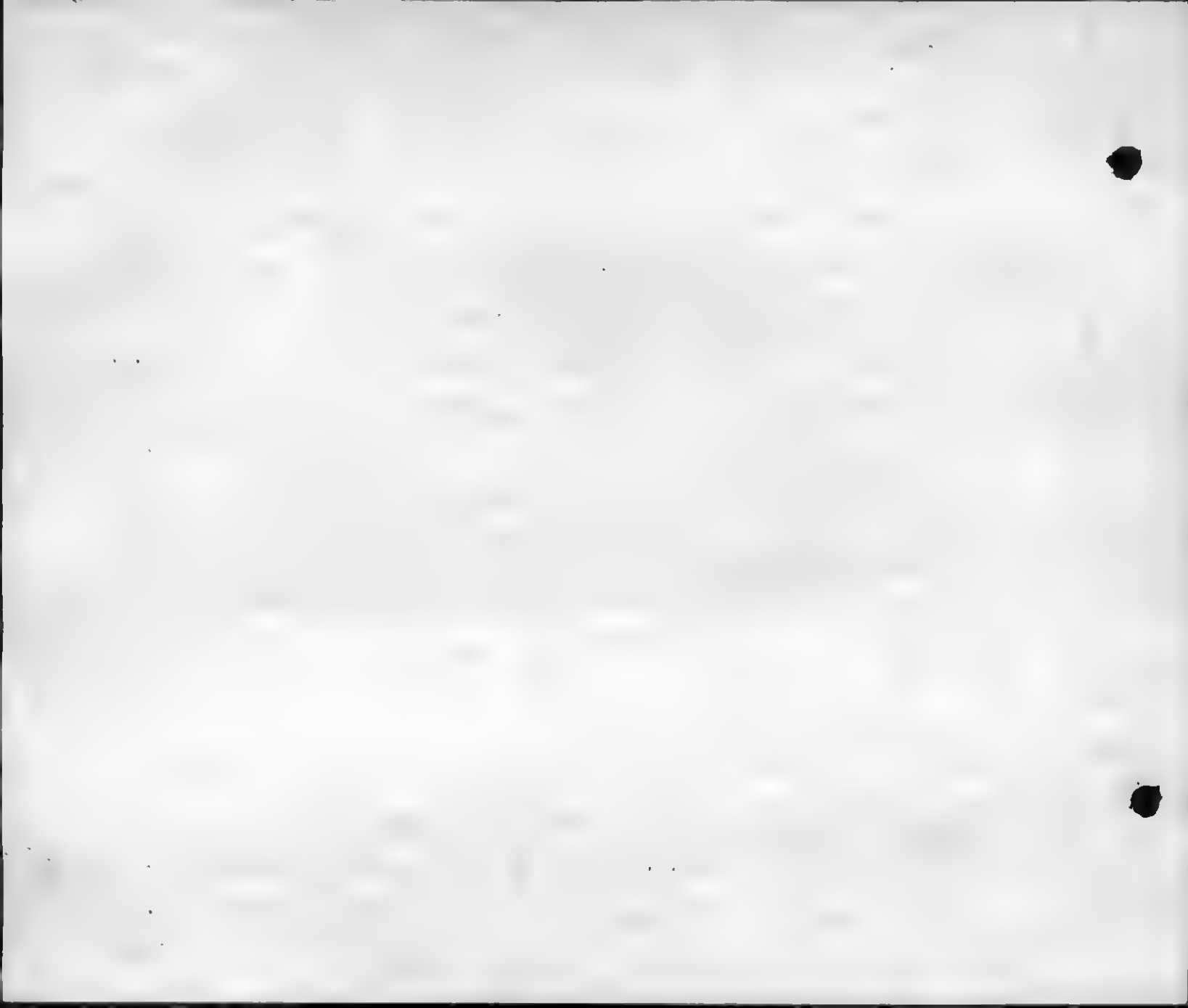
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04211 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04208

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b MARYLAND	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 Patapsco Ave.		e. STREET ADDRESS 120 Patapsco Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Ehrbaker		First Middle Last (A.K.A. Baker)		4. DATE OF DEATH April 19 19 62	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 21, 1889		9. AGE (In years, last birth day) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Philip Ehrbaker		14. MOTHER'S MAIDEN NAME Eva von Brunen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Philip H. Ehrbaker, 2715 Margate Rd.-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver & Biliary System DUE TO (b) DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) None		INTERVAL BETWEEN ONSET AND DEATH 6-8 mos		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21f. (City or town)		21g. (County)		21h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M B Davis		M.D. Melvin B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/25/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-23-62		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
22d. LOCATION (City, town, or county) Baltimore County, Md.		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE William S. Kraus	
23. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.		ADDRESS		DATE APR 25 '62	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

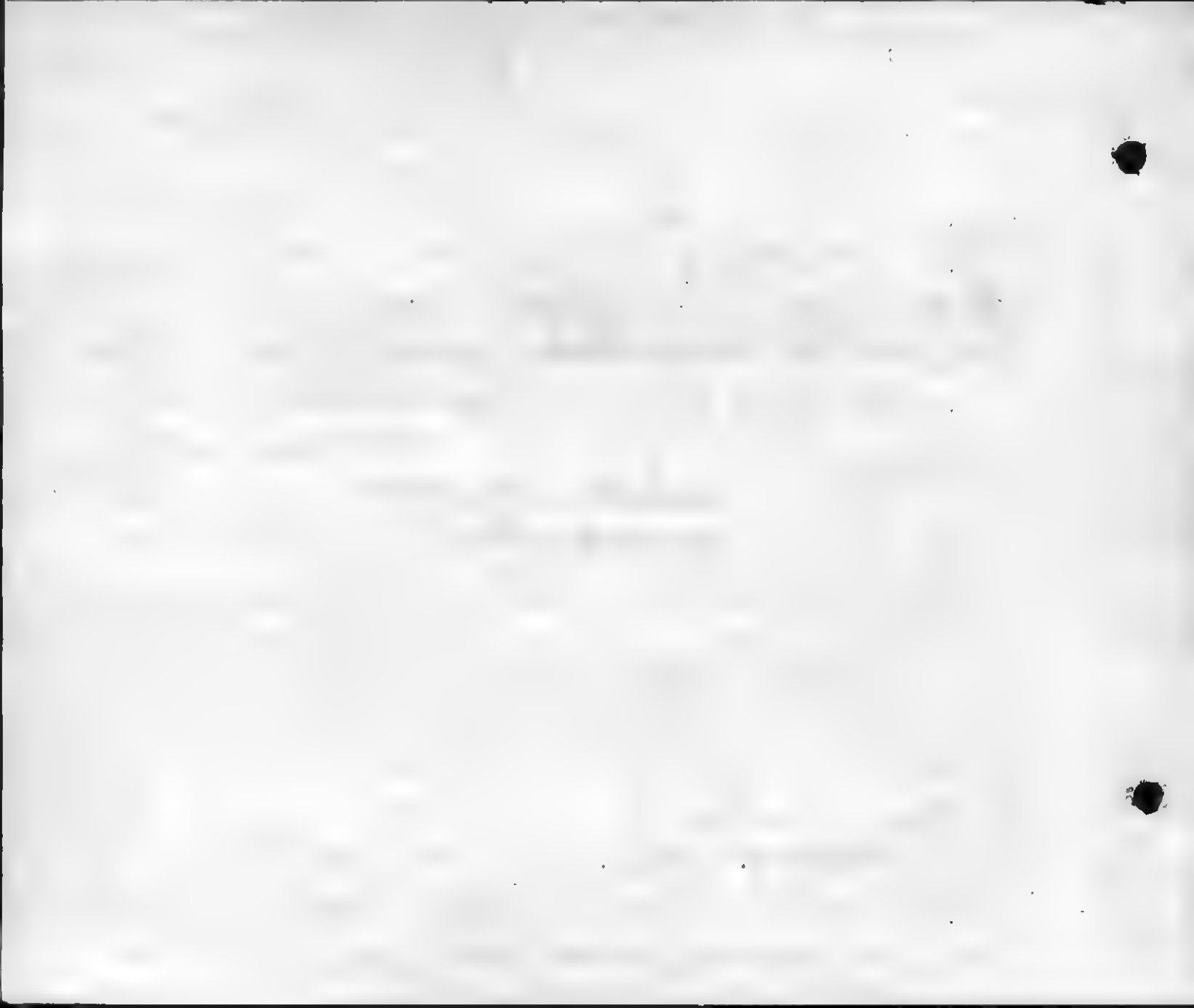
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04209

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN IL <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6630 Marrott Ave</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>MILLARD N. EHRMAN</u>		4. DATE OF DEATH <u>APRIL 7 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1910</u>
9. AGE (in years last birthday) <u>52 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> M n. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Financial Loans</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Administration</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Late Ansel Ehrman</u>		14. MOTHER'S MAIDEN NAME <u>Late Bessie Nusbaum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>337-01-7007</u>	
17. INFORMANT <u>Mrs. Betty Ehrman - Same</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>15 -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma colon</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mths</u> <u>yes?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, 18. <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4/5, 1962</u> to <u>4/7, 1962</u> that (I) (we) last saw the deceased alive on <u>4/5, 1962</u> and that death occurred at <u>8 PM</u> from the causes and on the data stated above.			
22a. SIGNATURE <u>Maurice Feldman Jr.</u> M.D.		22b. DATE SIGNED <u>4/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. Maurice Feldman Jr.</u>		22d. ADDRESS <u>2 E Read St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4/8/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Linnick & Bros. 6010 Reisterstown Rd</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	
ADDRESS <u>#15</u>		DATE <u>APR 11 '62</u>	



04213

CERTIFICATE OF DEATH

Reg. Dist. No.

04210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Towson			c. LENGTH OF STAY IN 1b Two (2) years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				d. STREET ADDRESS 527 Hampton Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pearl First Blanche Middle Eichhorn Last				4. DATE OF DEATH April Month 8 Day 19 Year 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1884	
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Deaver				14. MOTHER'S MAIDEN NAME Elizabeth Burton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Donna Barrett, R.N., 1439 Burton Ave			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO GENERALIZED ARTERIOSCLEROSIS & HYPERTENSION (b) PEPTIC ULCER, CONGESTIVE HEART FAILURE DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 WKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/22 19 59 to 4/8 19 62 , that I last saw the deceased alive on 4/8 19 62 , and that death occurred at 9:30 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 206 W. Pennsylvania Avenue DATE SIGNED 4/9/62 ACTUAL SIGNATURE T.C. Siwinski M.D. PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M.D. Towson 4, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-62		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson Inc.				ADDRESS Towson 4, Maryland		24a. REC'D BY REGISTRAR APR 11 1962	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hana			

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04211

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN <u>5yr11mth12dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton, Md.</u> d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) First <u>Spencer</u> Middle <u></u> Last <u>Ensor</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1888</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR <u></u> IF UNDER 24 HRS. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. RR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hutchinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-6868</u>	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Adhesive pericarditis; unknown etiology</u> (c) <u>Cardiac hypertrophy and dilatation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 4 50</u> 19 <u>62</u> , to <u>April 23</u> 19 <u>62</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 23</u> 19 <u>62</u> , and that death occurred at <u>8:10</u> a.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u>		22b. DATE SIGNED <u>4-23-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 26, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monkton Meth. Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Monkton, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Shacter</u>		25a. REC'D BY REGISTRAR <u>DATE APR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Ernest J. Thomas</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

SS Iirqa

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
04212

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04212

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 15 <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2014 Rockwell Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u> d. STREET ADDRESS <u>2014 Rockwell Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Charles V. Ernest, Sr.</u>		4. DATE OF DEATH <u>April 23 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1898</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> M'n. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-V. Pres.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pressmans Union</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Ernest</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Charles V. Ernest, Jr.</u>		Address <u>2014 Rockwell Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>331X</u> DUE TO (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Jan 4/23</u> 19 <u>60</u> to <u>4/23</u> 19 <u>62</u> , that (I) <u>was</u> last saw the deceased alive on <u>4/23</u> 19 <u>62</u> , and that death occurred at <u> </u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James Nolan</u>		22b. DATE SIGNED <u>4/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>S S NOLAN</u>		22d. ADDRESS <u>1 Melrose Hill Ave Ball A Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THE COF <u>4-26-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State) <u> </u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J Sackner & Sons</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	

APR 27 '62



TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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(I)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

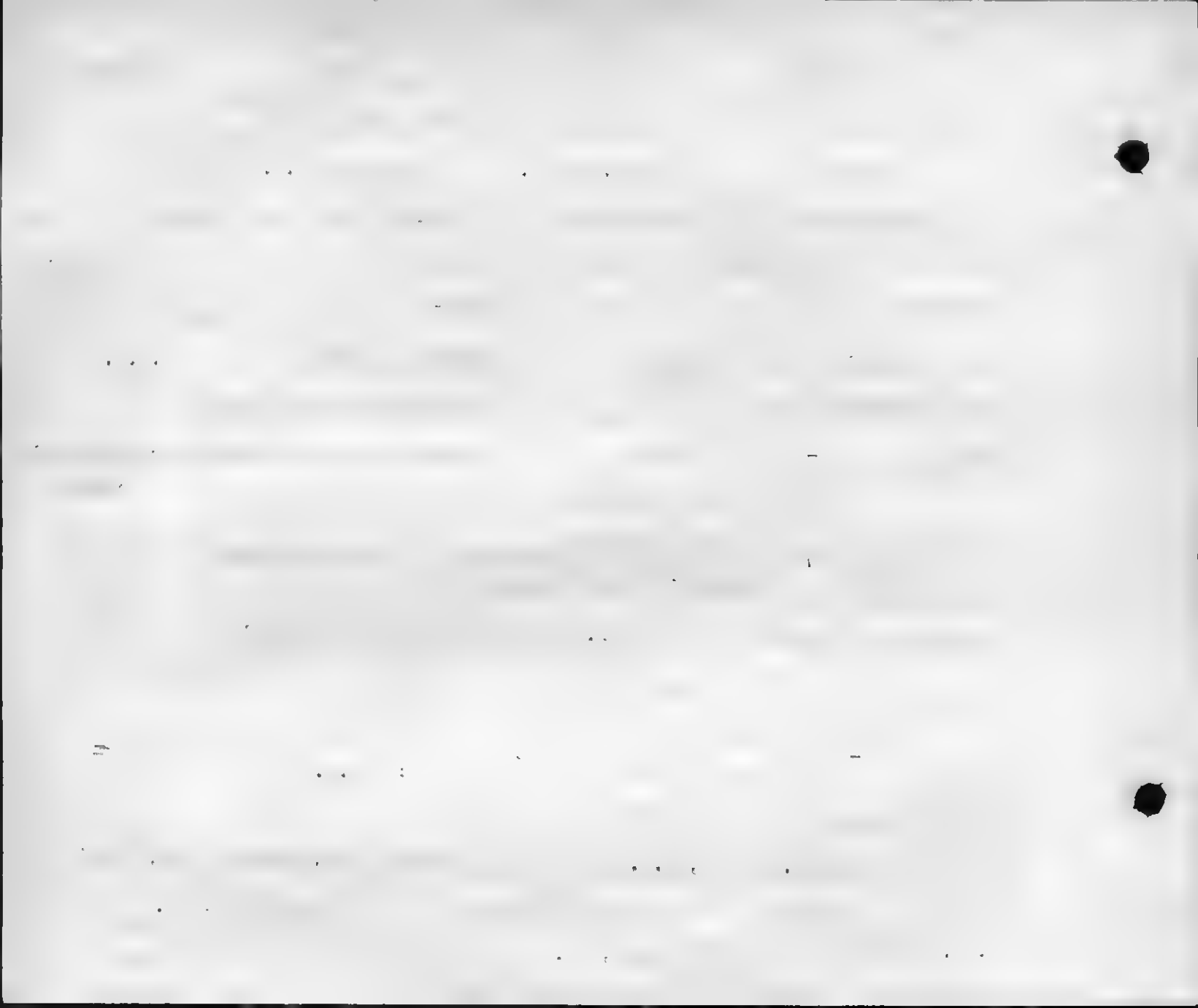
CERTIFICATE OF DEATH

04216

04213

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 7 mos. 10 da. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS Walter Reed Army Hospital	
3. NAME OF DECEASED (Type or print) Lucinda Faye EVANS		4. DATE OF DEATH Month 4 Day 15 Year 19 62	
5. SEX Female 6. CO. OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/61 9. AGE (In years last birthday) 11 yrs. 5 months 5 days 15 hours 62 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (County & State, or foreign country) Everoux, France 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Morton Evans 14. MOTHER'S MAIDEN NAME Judith Carol Young (Evans)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Rosewood Records, Owings Mills, Maryland.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO (b) Acute bronchitis DUE TO (c) Arnold Chiari malformation (hydrocephalus, non-communicating; meningomyelocele). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Liekenschadel anomaly of the skull. Meningitis (pseudomonas aeruginosa)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5		20d. (City or town) 4/15 (County) Prince Georges (State) Md.	
21. I certify that (4) (this hospital) attended the deceased from 9/5 to 4/15 , 19 62 , that (4) (we) last saw the deceased alive on 4/15 , 19 62 , and that death occurred at 6:55 P.M. from the causes and on the date stated above.		22a. SIGNATURE Harry G. Butler M.D. 22b. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. 22c. ADDRESS Rosewood Lane, Owings Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/18/62 23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery 23d. LOCATION (City, town or county) Owings Mills, Md. (State) Md.		24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons ADDRESS Reisterstown, Md. 25a. REC'D BY REGISTRAR APR 23 '62 25b. REGISTRAR'S SIGNATURE William S. Kline	

1191



1
FOR STATE
HEALTH DEPT.

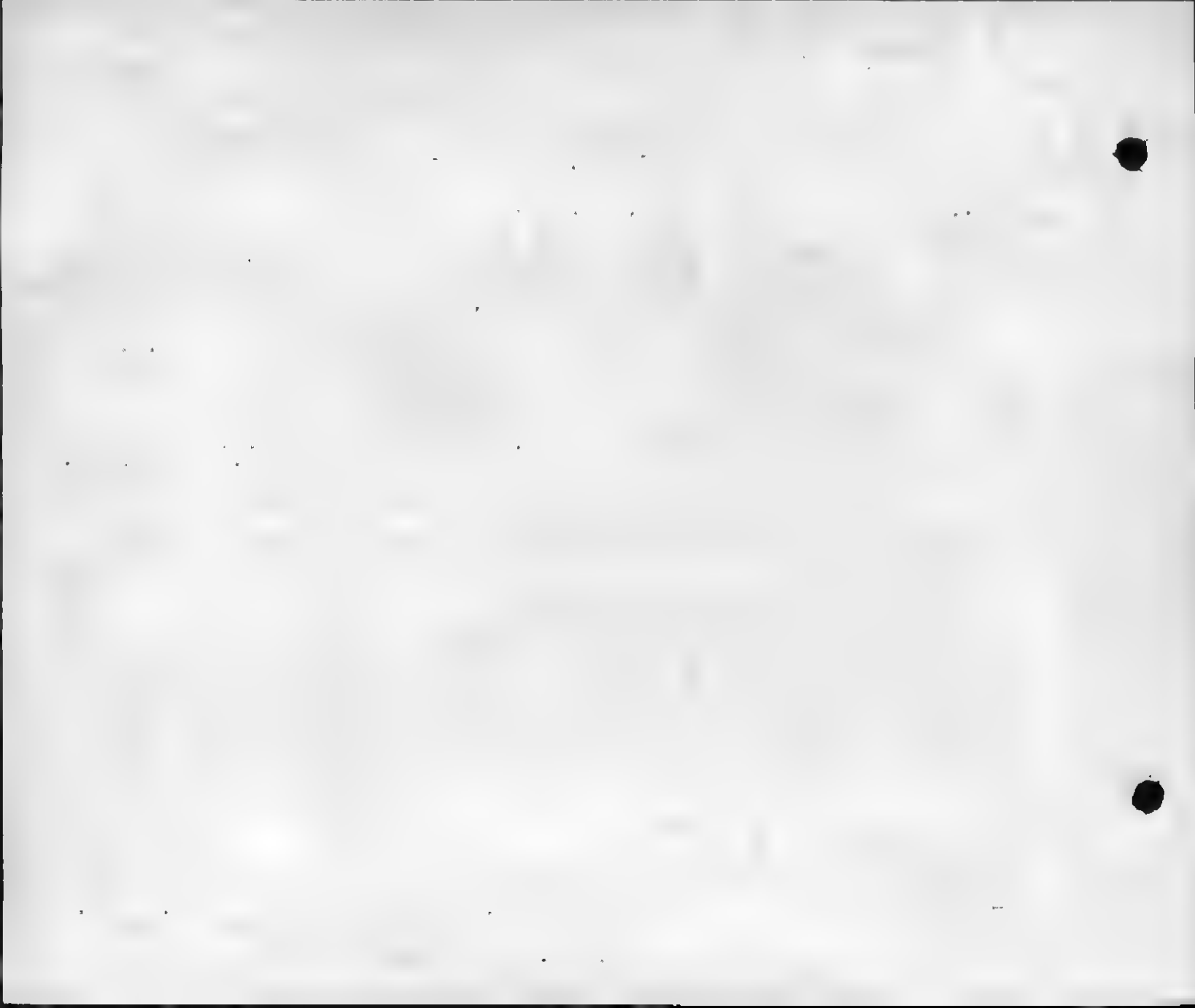
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

<div> <div> <div>1</div> <div>04217</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>04214</div> </div> </div> <div> <div>FOR STATE HEALTH DEPT.</div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penwood Terrace				c. LENGTH OF STAY IN 1b 25 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Penwood Terrace			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Res., 8603 North Point Road, 19,				d. STREET ADDRESS 8603 North Point Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GRACE Ellen Ewing				4. DATE OF DEATH 4-4-1962							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alec Alford				14. MOTHER'S MAIDEN NAME Louisa Walters							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Lucille Sherrow P.O. Box 183 Ft. Howard, Md.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Jack Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4-4-62			
EXAMINER'S NAME (Type) JACK COLLINS				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-7-1962 Burial				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		22d. LOCATION (City, town, or country) (State) Washington Blvd. Md.			
23. FUNERAL DIRECTOR JOHN J. DIUDA 7922 Wise Ave. 22, Md.				ADDRESS				24a. REC'D BY REGISTRAR APR 5 '62		24b. REGISTRAR'S SIGNATURE William L. Hume	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
3 days 10 hrs



TO HOSPITAL

VR AIS 41
TSM 7.61

CERTIFICATE OF DEATH

04215

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		b. COUNTY Baltimore 2	
c. LENGTH OF STAY IN b. 12020		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 621 East Biddle Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bent Nursing Home, 12020 Reisterstown Road		d. STREET ADDRESS 621 East Biddle Street	
3. NAME OF DECEASED (Type or print) MARGARET S. FAGERLAND		4. DATE OF DEATH Month April Day 18 Year 1962	
5. SEX Female		6. DATE OF BIRTH Aug. 19, 1878	
6. COLOR OR RACE white		7. AGED (in years last birthday) 83 yrs.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. IF UNDER 1 YEAR Months 8 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. May Fischer, 3005 Kentucky Avenue Zone 13		18. ADDRESS Zone 13	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIO SCLEROTIC C. V. DISEASE (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 HRS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/5 1962 to 4/18 1962, that (I) (we) last saw the deceased alive on 4/17 1962, and that death occurred at 7:52 AM , from the causes and on the date stated above			
22a. SIGNATURE Martin E. Strobel		22b. DATE SIGNED 4/18/62	
22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL		22d. ADDRESS REISTERSTOWN, MD.	
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE THEREOF 4-21-62	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City, town or county) (State) Taylor Ave & Dalesford Rd	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE C. E. S. Thomas		25c. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04219

04216

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>120 Kinship Road</u>				e. STREET ADDRESS <u>120 Kinship Road</u>			
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>E.</u> Last <u>FAHEY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18th</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heater</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Fahey</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Needham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-07-0649</u>			
17. INFORMANT <u>Maude T. Fahey</u>				Address <u>same as "2"</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4:30 p.m. DUE TO (b) <u>A-S-C-V DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>Baltimore</u>				20g. (County) <u>Baltimore</u>		20h. (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Melvin B. Davis, M.D. <u>Dundalk 22, Maryland</u> NAME (Type) Address (Street, city, town, or country) DATE SIGNED <u>4/20/62</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/23/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>	
22d. LOCATION (City, town, or country) <u>Baltimore, Maryland</u>				22e. (State) <u>Maryland</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Inc., Dundalk 22, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 (3) 04220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04217

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN town
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 407 Forest Lane

2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)
a. STATE Md b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
d. STREET ADDRESS 407 Forest Lane

3. NAME OF DECEASED (Type or print) Flossie May ~~Fanny~~ Faidley
First Middle Last
4. DATE OF DEATH April 23, 1962 Month Day Year
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Jan. 1, 1884 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home duties 10b. KIND OF BUSINESS OR INDUSTRY Home 11. ETHNIC RACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wyncoo Dickey 14. MOTHER'S MAIDEN NAME Nettie Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] [If yes give war or dates of service] 16. SOCIAL SECURITY NO. 47 17. INFORMANT John W. Faidley Address 407 Forest Lane 28

10. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-28-1 DUE TO Acute Coronary heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Cardio vascular disease, Arterio sclerosis (c)		

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? 11
YES ☐ NO ☒

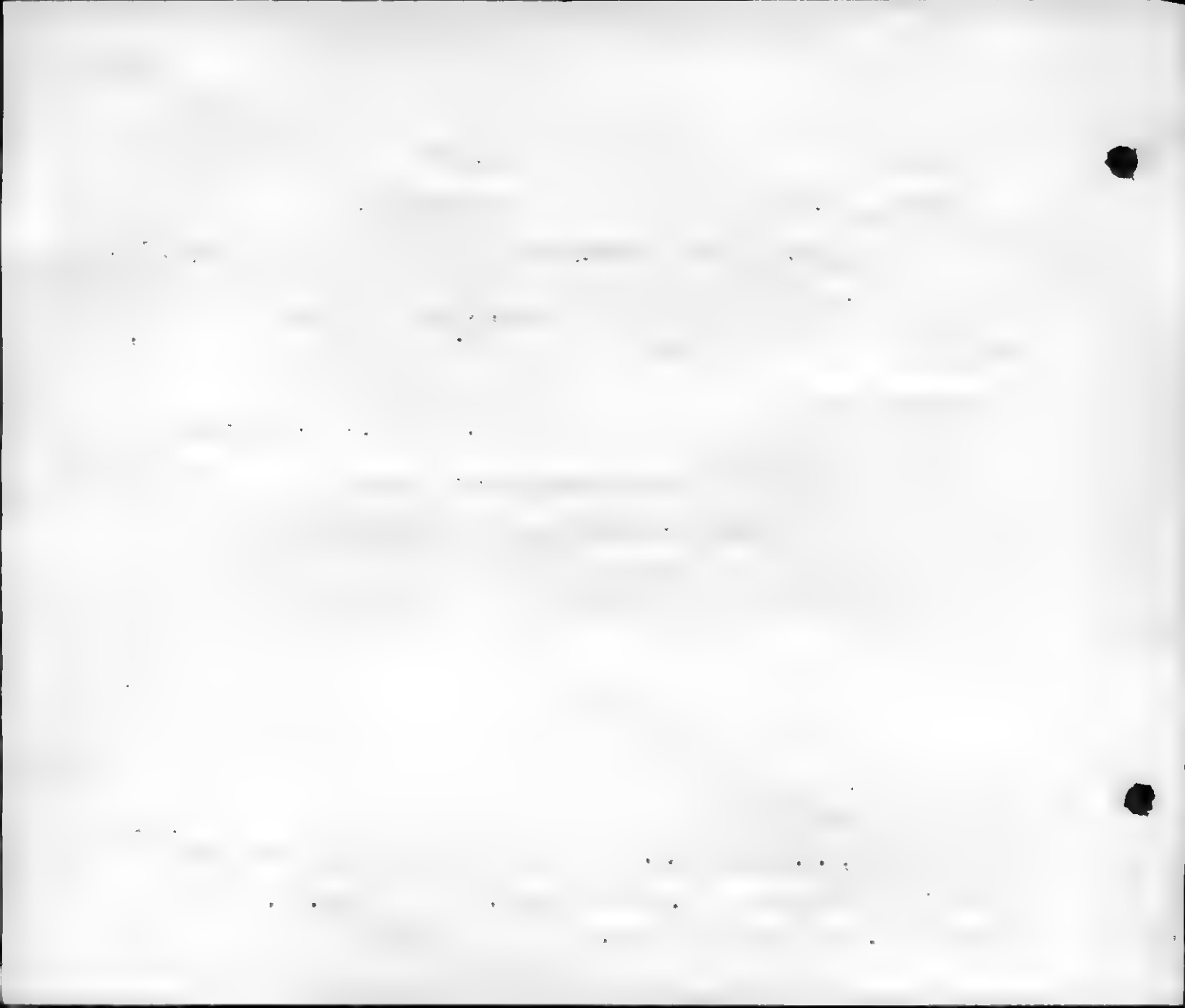
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)						
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
Month	Day	Year	While at work <input type="checkbox"/>	Not While at work <input type="checkbox"/>				
Hour	a.m.							
	p.m.	19						

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE *Geo M. Kieffer* CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) M D ASSISTANT MEDICAL EXAMINER ☐
Geo. S. M. Kieffer M.D. DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED \$-23-62
Address (Street, city, town, or county) 1010 Leeds Ave

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	4/26/62	Mt.Olivet Cemty.	Balto.Md.

23. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave.		ADDRESS		24a. REC'D BY REGISTRAR APR 26 '62	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
DATE					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.M. AIME
SM 7/59

FOR STATE
HEALTH DEPT.

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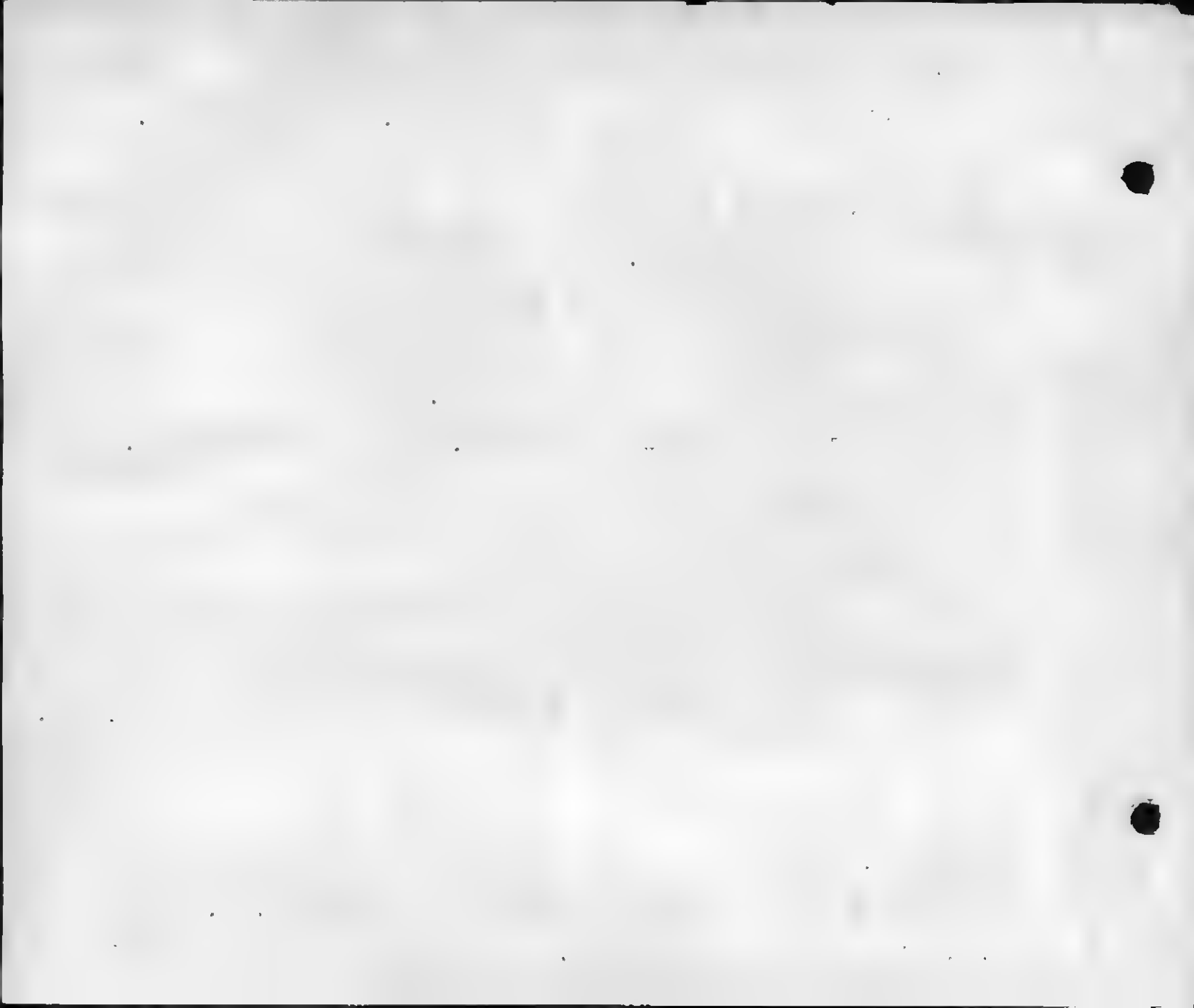
34

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04221

04218

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Hanover Road		d. STREET ADDRESS Old Hanover Road	
3. NAME OF DECEASED (Type or print) Richard J. Farace		4. DATE OF DEATH April 13, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH May 30, 1896	9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vincent Farace		14. MOTHER'S MAIDEN NAME Rose A. Scalco	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 216-01-6859	
17. INFORMANT Richard J. Farace		Address Easton Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Brain Damage			
DUE TO (b) Fractured Skull			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto driven by deceased struck by train	
20c. TIME OF INJURY Month, Day, Year 2:30 a.m. 1/13/62		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Reisterstown, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Martin E. Strobel		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Martin E. Strobel		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Reisterstown, Balto., Co.		DATE SIGNED 1/14/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16, 62	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		22d. LOCATION (City, town, or country) (State) Finksburg, Md.	
23. FUNERAL DIRECTOR J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR APR 17 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

04222

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04219

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION All Saint's Convent		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Agnes of all Saint's		4. DATE OF DEATH April 23, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1869
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professed Sister		10b. KIND OF BUSINESS OR INDUSTRY Sisters of the poor	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rev. William George Farrington		14. MOTHER'S MAIDEN NAME Anne W. Kip	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT All Saint's Convent		Address Catonsville - 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial Decomensation 4-22-1 DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH 2 mo. 10 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-1- 19 60 to 4-23- 19 62 that (I) (the) last saw the deceased alive on 4-21- 19 62 , and that death occurred on 4-23- 19 62 from the causes and on the date stated above			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE 4/24/62	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M. D.		22d. ADDRESS 2609 Frederick Ave. Catonsville - 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/25/1962	23c. NAME OF CEMETERY OR CREMATORY All Saint's Convent Cem.	23d. LOCATION (City, town, or county) (State) Catonsville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR DATE APR 27 '62	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

MEDICAL CERTIFICATION

1. The first part of the document

describes the general situation

and the main objectives of the study

2. The second part of the document

describes the methodology used

3. The third part of the document

describes the results of the study

4. The fourth part of the document

describes the conclusions of the study

5. The fifth part of the document

describes the recommendations of the study

6. The sixth part of the document

7. The seventh part of the document

describes the references of the study

8. The eighth part of the document

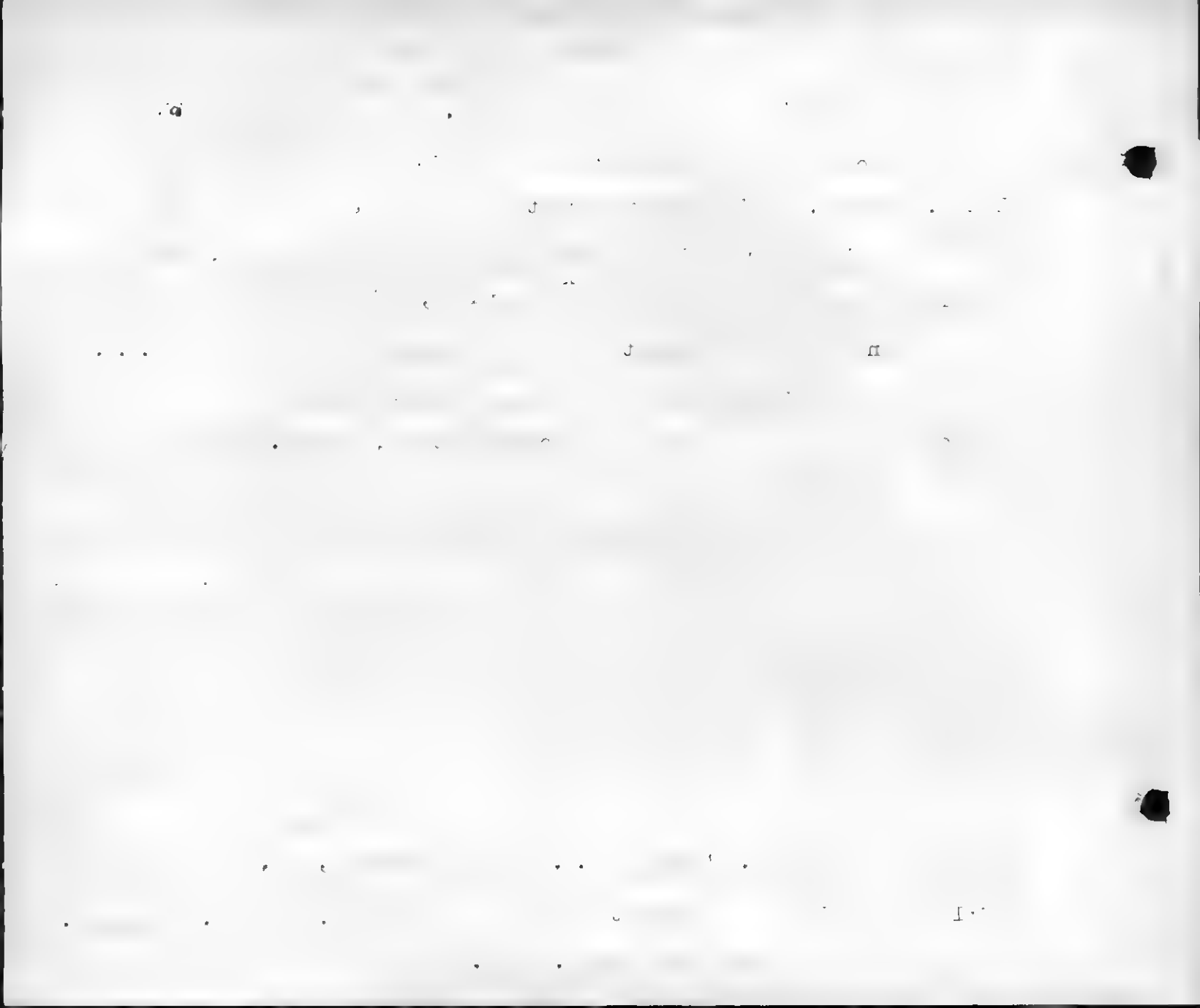
04223

CERTIFICATE OF DEATH

Reg. Dist. No. 04220

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 W. Joppa Rd. Mission Helpers Convent		d. STREET ADDRESS 1001 West Joppa Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Isaia (Finneran)		4. DATE OF DEATH Month Day Year April 7, 1962 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1875
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Finneran		14. MOTHER'S MAIDEN NAME Mary Hanley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Convent Records, 1001 W. Joppa Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma of Breast DUE TO (c) 6 mos. 3 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19 49 to April 7 1962 , that I last saw the deceased alive on April 24 1962 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) 7501 York Road	
NAME (Type) Charles F. O'Donnell, M.D.		DATE SIGNED 4/19/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/62	
22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lemmon		ADDRESS 4611 Park Heights. Balto.	
24a. REC'D BY REGISTRAR APR 10 '62		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04224
04221
04221

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY HALL
c. LENGTH OF STAY IN 1b 2 1/2 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Joppa Road

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall
d. STREET ADDRESS Joppa Road

3. NAME OF DECEASED (Type or print) First Middle Last EDMUND J FISCHER
4. DATE OF DEATH Month Day Year April 24 1962

5. SEX M. 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH May 1 1876
9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Germany
11. BIRTHPLACE (County & State, or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frederick Fischer
14. MOTHER'S MAIDEN NAME Theresa Potosch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No
16. SOCIAL SECURITY NO. 220-34-573
17. INFORMANT Walter Fischer Address Joppa Rd. Perry Hall Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO Artherosclerotic coronary vasc. disease
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

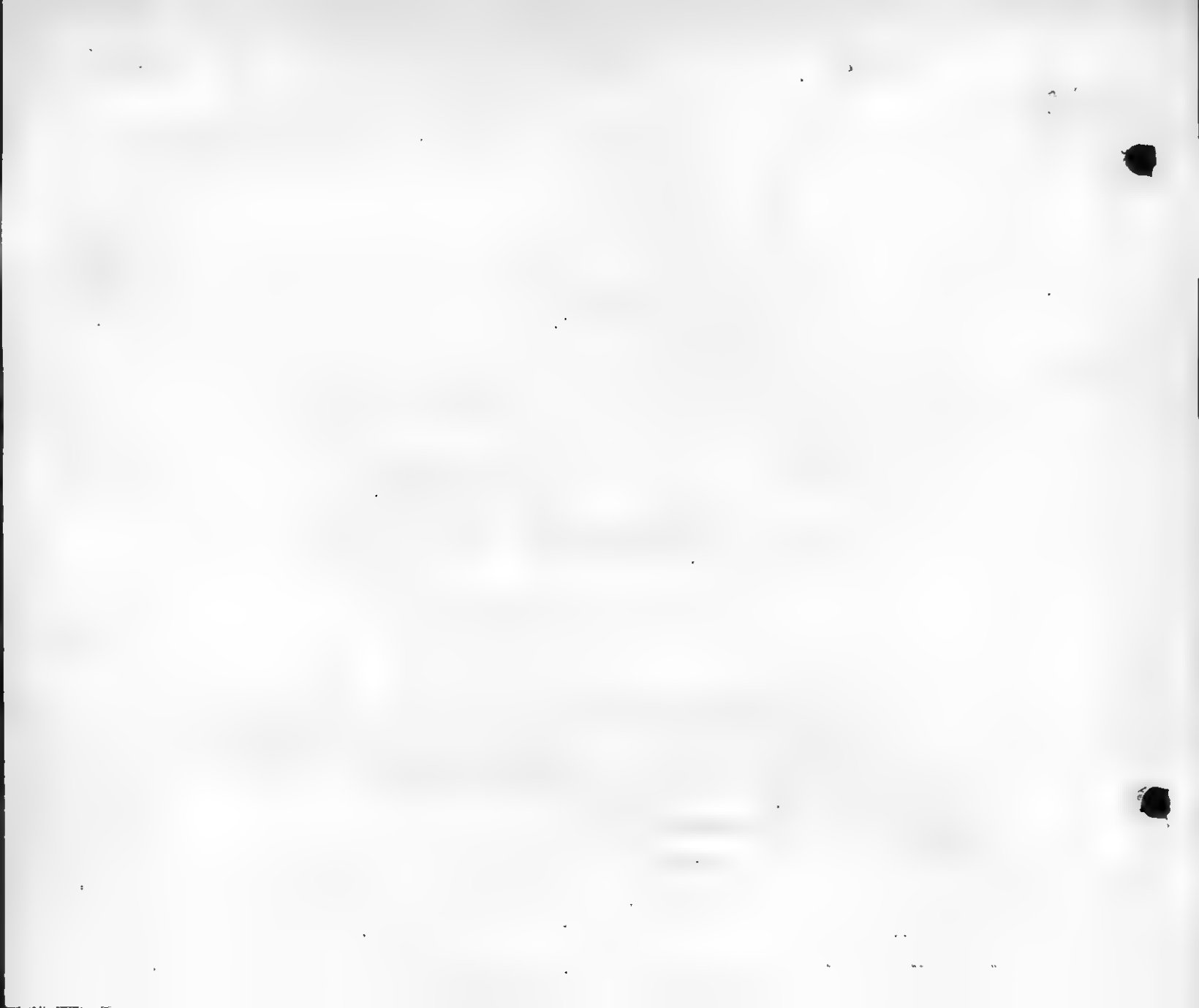
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1950 to April 24, 1962, that (I) (we) last saw the deceased alive on Apr. 24 1962, and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE Louis Semenovoff M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 4/25/62
22c. PHYSICIAN'S NAME (Type) LOUIS SEMENOFF 22d. ADDRESS 2108 CRENS RD, BACTO 20, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Apr. 27-62
23c. NAME OF CEMETERY OR CREMATORY Zion Luth. Cem 23d. LOCATION (City, town or county) (State) Balto Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE Lassohn Fun'l Home ADDRESS 7901 Belair Rd
25a. REC'D BY REGISTRAR APR 30 '62 25b. REGISTRAR'S SIGNATURE Wm. L. Thoma



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04225

CERTIFICATE OF DEATH

04222

M

X

I

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson Balto. County		c. LENGTH OF STAY IN TB 6 weeks		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Penna.		b. COUNTY Lancaster	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1710 Edgewood Road Towson, 4, Md.		e. STREET ADDRESS 119 Juniata St. Lancaster		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) Anna May Fisher		4. DATE OF DEATH Apr. 18 1962	
5. SEX F.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1879		9. AGE (In years last birthday) 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Penna. Strasburg, Lancaster Co.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Mowery	
14. MOTHER'S MAIDEN NAME Mary McCleary		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Paul Rife, 1710 Edgewood Rd. Towson, 4, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia DUE TO (b) Hemiplegia DUE TO (c) Arteriosclerosis with Cerebral Thrombosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)		21. I certify that (I) (this hospital) attended the deceased from 3/1/62 to 4/1/62 , that (I) (we) last saw the deceased alive on 4/1/62 , 19 62 , and that death occurred at 2 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Wm. Conway		22b. DATE SIGNED 4/18/62		22c. PHYSICIAN'S NAME (Type) W. M. Conway MD		22d. ADDRESS 8358 Loch Raven Blvd. Towson 4, Md.		22e. REC'D BY REGISTRAR APR 23 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/18/62		23c. NAME OF CEMETERY OR CREMATORY Riverview Burial Park		23d. LOCATION (City, town or county) Strasburg, Penna.		23e. REGISTRAR'S SIGNATURE Arthur L. Hines	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. 1050 York Rd.		24b. ADDRESS 4		24c. DATE APR 23 '62		24d. REGISTRAR'S SIGNATURE Arthur L. Hines		24e. DATE APR 23 '62	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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04226

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04223

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>most of life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeysville</u>	
		d. STREET ADDRESS <u>Church Lane</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE REBECCA FORD</u> Middle Last		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George McFATRIDGE</u>		14. MOTHER'S MAIDEN NAME <u>LAURA VIRGINIA SLADE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Elsworth Ford</u>		Address <u>Cockeysville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia, coronary sclerosis</u> 420 a) DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>cardiovascular disease</u> (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days, yrs.</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1947</u> to <u>April 11, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 11, 1962</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Sherrill M.D.</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>		22d. ADDRESS <u>Cockeysville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-14-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cockeysville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Inc. Towson 4, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 501 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04227

CERTIFICATE OF DEATH

04224

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		Items 13 & 14 Film 11-11-12/62 mb Items 8 & 9 Film 11-11-12/62 mb		USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN IN <u>Ind.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>23 Leslie Ave.</u>		d. STREET ADDRESS <u>23 Leslie Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>	First <u>L.</u> Middle <u>Forrest</u> Last <u>Forrest</u>	4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1962</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1888</u>		9. AGE (In last b. year) <u>73</u> Months <u>7</u> Days <u>19</u> Hours <u>62</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Wehr</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lewis</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>P. Vernon Forrest Sr.</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>Coronary Thrombosis</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>uncertain</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>4-7</u> 19 <u>59</u> to <u>4-7</u> 19 <u>62</u> , that (I) (was) last saw the deceased alive on <u>4-7</u> 19 <u>62</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Paul G. Mueller</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-7-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL G. MUELLER</u>		22d. ADDRESS <u>6411 Belair Rd. Balt. 6 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Ind.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc.</u>		ADDRESS <u>5305 Harford Road</u>		25a. REC'D BY REGISTRAR DATE <u>APR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>					



1
FOR STATE
HEALTH DEPT.
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04225

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT c. LENGTH OF STAY IN IT 45 YRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT d. STREET ADDRESS 1018 I STREET	
3. NAME OF DECEASED (Type or print) PAUL FOSTER		4. DATE OF DEATH Last 18 Month APRIL Day 19 Year 62	
5. SEX MALE		6. COLOR OR RACE C	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 JUNE 1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		11. BIRTHPLACE (State or foreign country) HALIFAX COUNTY, VA.	
10b. KIND OF BUSINESS OR INDUSTRY STEEL		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JIM FOSTER		14. MOTHER'S MAIDEN NAME FANNIE FOSTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-09-5434A	
17. INFORMANT MARY WILLIE FOSTER (W)		Address 1018 I ST. SPARROWS PT.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① H-S-C-V Disease Conditions, if any, which gave rise to immediate cause (b) Bi-lateral Pyelonephritis & LRV (c) Nephrolithiasis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 mos		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DR. MELVIN B. DAVIS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 22 APRIL 62	
22c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM'L PK.		22d. LOCATION (City, town, or country) (State) BALTO. COUNTY, MD.	
23. FUNERAL DIRECTOR CHARLES G. COOPER		24. REC'D BY REGISTRAR 512 CARROLLTON AV. BALTO. MD. 18 '62	
24b. REGISTRAR'S SIGNATURE W. L. Davis			

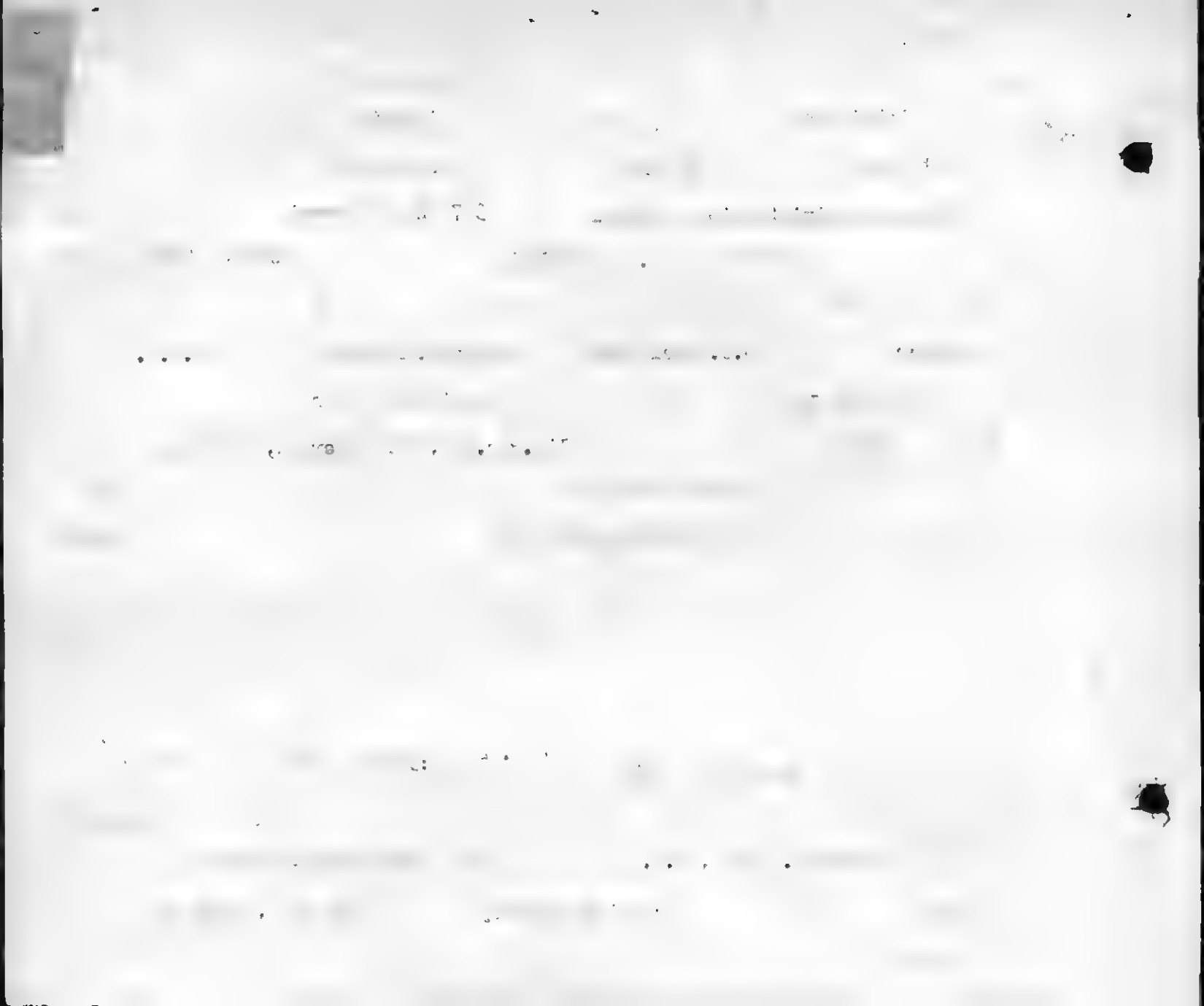


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03229
04226
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN IS 89 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Chincoteague c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 307 Church Street d. STREET ADDRESS 307 Church Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILTON H. FOXWELL		4. DATE OF DEATH Month APRIL Day 28TH Year 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/20/17	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR: Months 45 Days 45 Hours 45 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Base	
11. BIRTHPLACE (County & State, or foreign country) Somerset, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hayes Foxwell		14. MOTHER'S MAIDEN NAME Annie Dashields	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (b) BRONCHOGENIC CARCINOMA (c) 162.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 162.1		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 3 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Jan. 29 1962 to April 28 1962 that 11 (we) last saw the deceased alive on April 28 1962 , and that death occurred at 1:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Joshua A. Smith M.D.		22b. DATE SIGNED 4/28/62	
22c. PHYSICIAN'S NAME (Type) JOSHUA A. SMITH, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4-29-62	
23c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		23d. LOCATION (City, town or county) (State) Oak Hall, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc. 1217 ST PAUL ST, BALTO.		25a. REC'D BY REGISTRAR MAY 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Fries			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

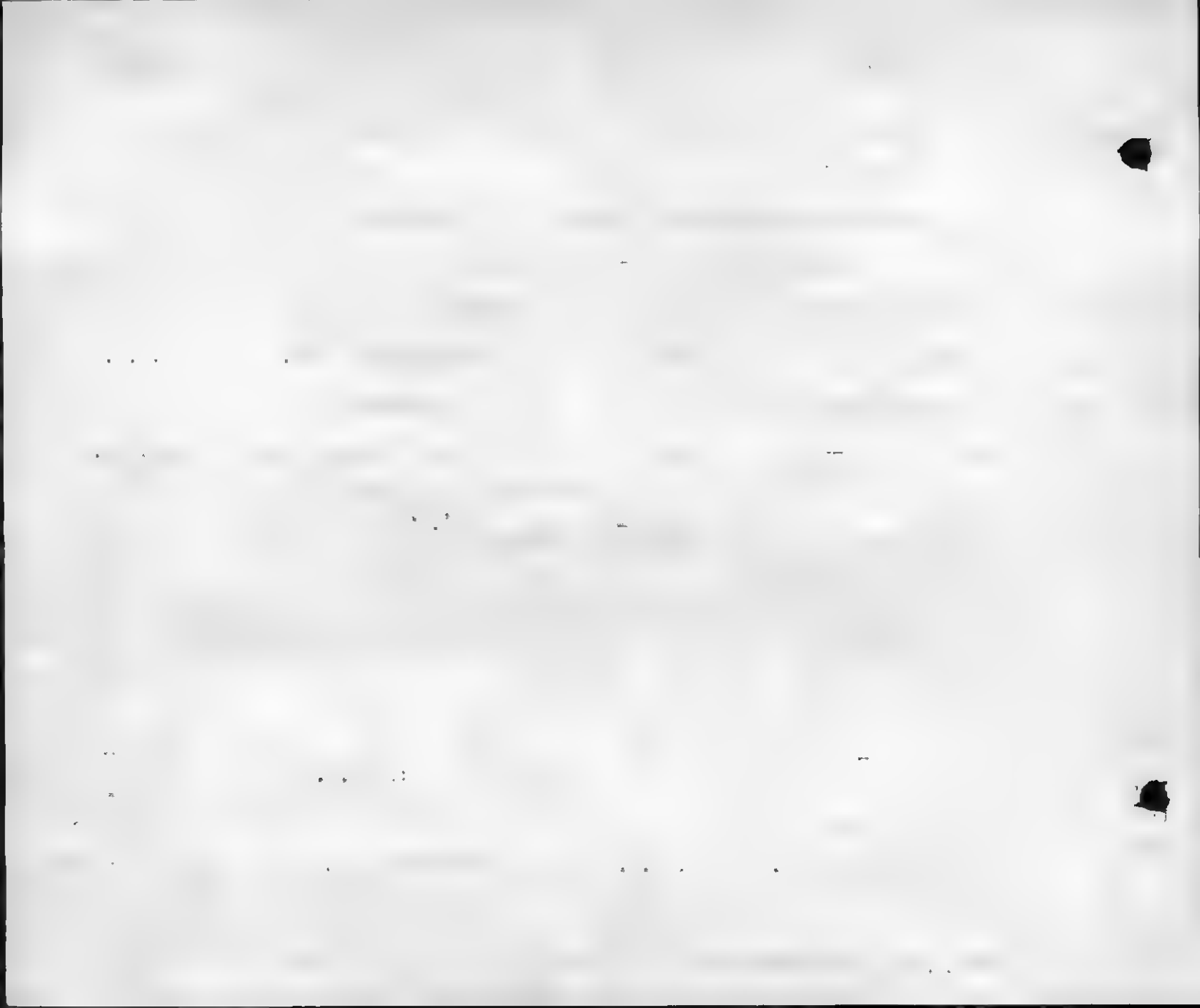
CERTIFICATE OF DEATH

04230

04227

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>4 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admission) a. STATE <u>Maryland</u> MARYLAND b. COUNTY <u>Baltimore 1,</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>666 West Franklin Street</u> d. STREET ADDRESS <u>3101 4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carolyn</u> First Middle Last 4. DATE OF DEATH <u>4</u> <u>2</u> <u>19 62</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/28/55</u> 9. AGE (in years last birthday) <u>6</u> yrs. <u>6</u> months <u>2</u> days <u>19</u> hours <u>62</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dependent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore City, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Carroll Shannon</u> 14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Garey Stokes</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Rosewood Records, Owings Mills, Md.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Bilateral Bronche pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute Bronchitis</u> (c) <u>Post meningococcal encephalitis with symptomatic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>encephalitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20. TIME OF INJURY Month, Day, Year <u>11/27</u> <u>1961</u> to <u>4/2</u> <u>1962</u> , that (H) (we) last saw the deceased alive on <u>4/2</u> <u>1962</u> , and that death occurred at <u>2:15 P.M.</u> the causes and on the date stated above. 21. I certify that (H) (this hospital) attended the deceased from <u>11/27</u> <u>1961</u> to <u>4/2</u> <u>1962</u> , that (H) (we) last saw the deceased alive on <u>4/2</u> <u>1962</u> , and that death occurred at <u>2:15 P.M.</u> the causes and on the date stated above. 22a. SIGNATURE <u>Harry G. Butler</u> 22b. DATE SIGNED <u>3 April '62</u> 22c. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u> 22d. ADDRESS <u>Rosewood Lane, Owings Mills, Maryland</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Apr. 6 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>W. Auburn Cem</u> 23d. LOCATION (City, town or county) <u>Baltimore Md</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ms Kate R Williams</u> 24a. REC'D BY REGISTRAR <u>APR 4 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

04231

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04228

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 477 Sunshine Ave</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Karl</u> Middle <u>A.</u> Last <u>Gabler</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Conrad</u>		14. MOTHER'S MAIDEN NAME <u>Roselle Snider Walther</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215079959</u>	
17. INFORMANT <u>Mary Gabler</u>		Address <u>Box 477 Sunshine Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ANGINA PECTORIS</u> DUE TO <u>CORONARY THROMBOSIS (2)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis.</u> (c) <u>Hyperthrophic Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 yrs</u> <u>14 yrs.</u> <u>18 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH GIVEN IN PART I (a) <u>Hyperthrophic Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/16</u> p. m. <u>54</u> 19 <u>4/1</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>9/16</u> to <u>4/1</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>62</u> and that death occurred at <u>8</u> A. M., from the causes and on the date stated above.			
22a. SIGNATURE OF ATTENDING PHYSICIAN <u>Clifford F. Hudson</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		22d. ADDRESS <u>FORK, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>APRIL 4 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEMORIAL GARDENS</u>		23d. LOCATION (City, town, or county) (State) <u>BELAIR MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. P. Bros.</u>		25a. REC'D BY REGISTRAR <u>APR 3 '62</u>	
ADDRESS <u>7110 Belair Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Clifford F. Hudson</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04232

04229

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1716 Wilson Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe
d. STREET ADDRESS 1716 Wilson Ave

3. NAME OF DECEASED (Type or print) Grace E. Berber
4. DATE OF DEATH April 18, 1962

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH Jan-17-1897
8. WIDOWED ☒ DIVORCED ☐ 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator - Factory 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, MD 11. BIRTHPLACE (County & State, or foreign country) USA. 12. CITIZEN OF WHAT COUNTRY USA.

13. FATHER'S NAME George C. Miller 14. MOTHER'S MAIDEN NAME Annie T. Keller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 215-28-8903 17. INFORMANT HELEN E. McINTYRE - SAME Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetic Mellitus 15 yrs 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (the hospital) attended the deceased from Aug 17, 1948 to April 18, 1962; that (I) (we) last saw the deceased alive on April 14, 1962, and that death occurred at 3 A.M. from the causes and on the date stated above.

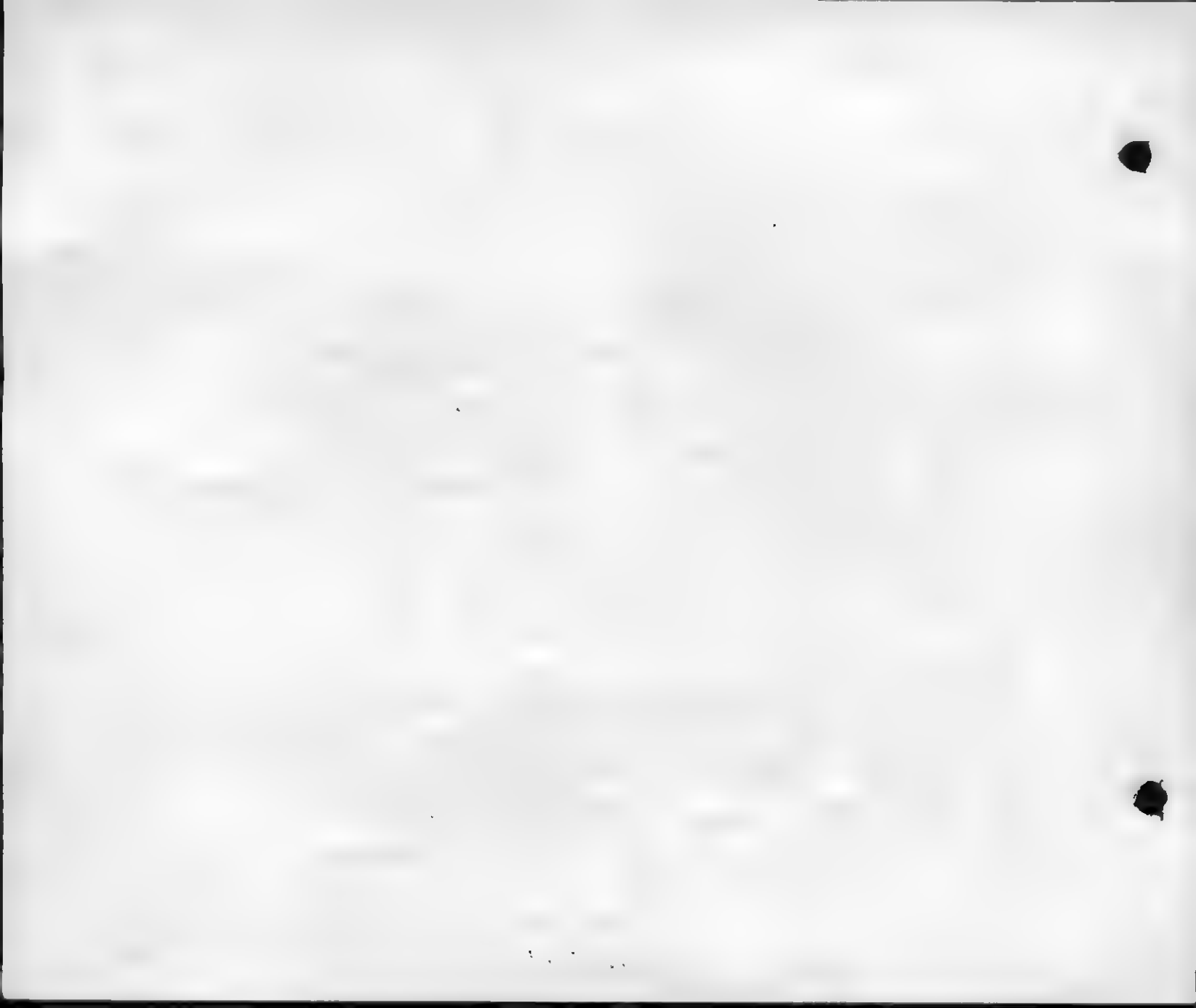
22a. SIGNATURE C. Arthur Rosenberg MD 22b. DATE SIGNED 4/20/62
22c. PHYSICIAN'S NAME (Type) C. ARTHUR ROSENBERG MD 22d. ADDRESS 2436 Washington Blvd. Balto - 30, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Apr 20/62 23c. NAME OF CEMETERY OR CREMATORY Heaven Park 23d. LOCATION (City, town or county) Balto, Maryland (State)

24. FUNERAL DIRECTOR'S SIGNATURE F. B. Wipfart - 1300 Eutan Pl. ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Harris

2436 Wash. Blvd.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

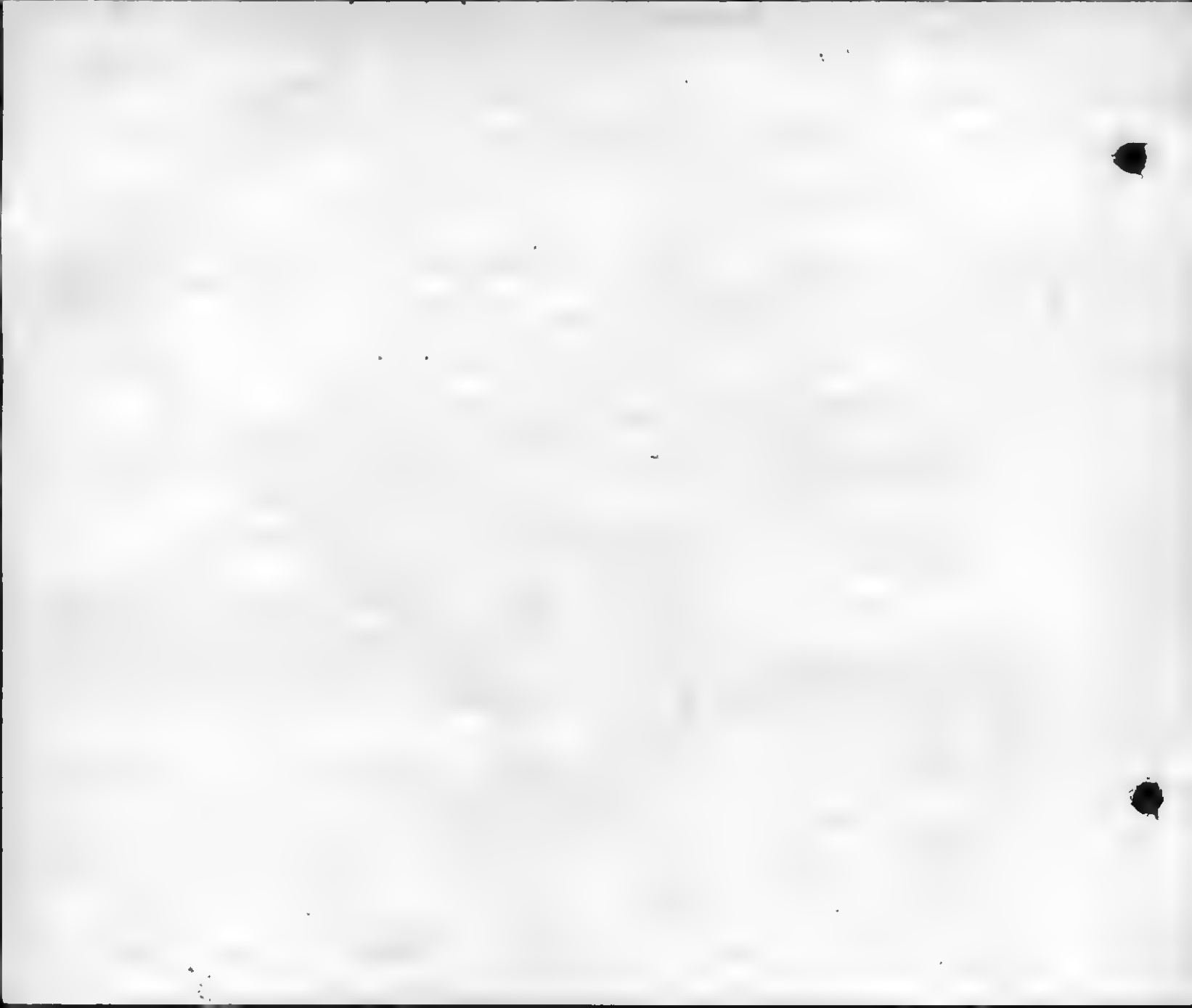
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04233

04230

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. LENGTH OF STAY IN <u>80</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9103 Old Harford Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
f. STREET ADDRESS <u>9103 Harford Road</u>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES W. GERMAN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-1875</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co.</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
11. FATHER'S NAME <u>Howell P German</u>		12. MOTHER'S MAIDEN NAME <u>Catherine P Stahl</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		14. SOCIAL SECURITY NO. <u>None</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> caused last. (c) <u>15 yrs.</u>		16. INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		18b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		18d. (City or town) (County) (State)	
19. I certify that (I) (the hospital) attended the deceased from <u>April 1962</u> to <u>April 1962</u> that (I) (we) last saw the deceased alive on <u>April 1962</u> and that death occurred <u>April 1962</u> from the causes and on the date stated above.			
20a. SIGNATURE <u>Charles W. German</u>		20b. DATE SIGNED <u>4/14/62</u>	
20c. PHYSICIAN'S NAME (Type)		20d. ADDRESS <u>8100 Harford Rd., Balto. Co., Md</u>	
21a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		21b. DATE THEREOF <u>4-17-1962</u>	
21c. NAME OF CEMETERY OR CREMATORY <u>Hiss Cemetery</u>		21d. LOCATION (City, town or county) (State) <u>Balto. Co Md</u>	
22. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		22a. ADDRESS <u>7401 Belair Road</u>	
22b. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>		22c. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate be retained by the hospital or attending physician. Page 4 of this certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04234

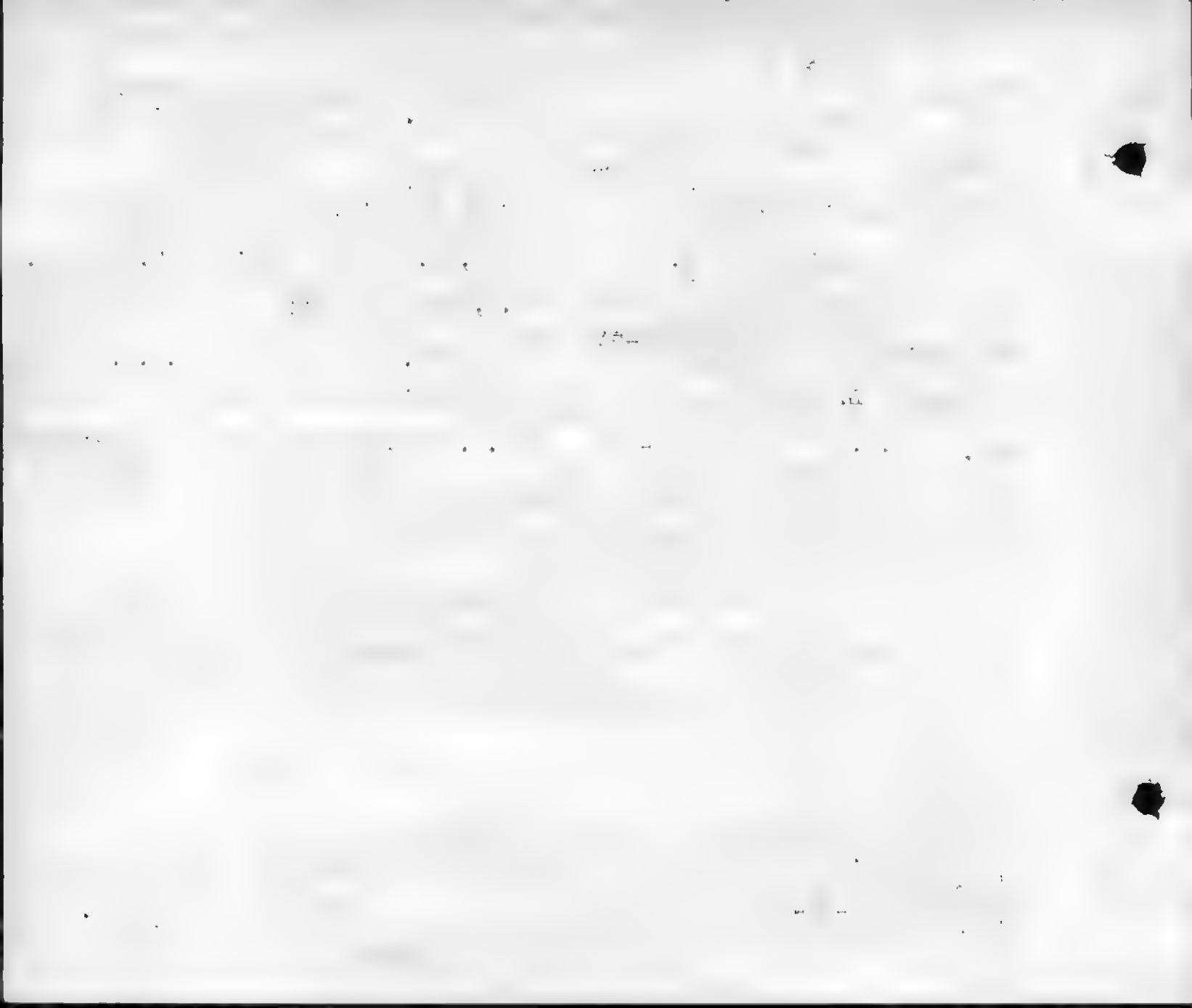
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

M

X

I

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: list name and address) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lakehurst		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lakehurst	
c. LENGTH OF STAY IN 1b 8 Yrs		d. STREET ADDRESS 6016 Lakeview Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6016 Lakeview Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle T. Last Gettorman, Sr.		4. DATE OF DEATH Month April Day 7 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 6, 1896
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President Wholesale Hardware		10b. KIND OF BUSINESS OR INDUSTRY Anderson and Ireland	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Gettorman		14. MOTHER'S MAIDEN NAME Catherine Ellenberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) W.W.1		16. SOCIAL SECURITY NO. 212-07-6793	
17. INFORMANT Mrs. M. Irene Gettorman		Address 6016 Lakeview Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Metastasis liver & Lungs (c) Metastasis liver & Lungs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval BETWEEN ONSET AND DEATH Dec 1961			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1961 to Apr 7 , 19 62 ; that (I) (we) last saw the deceased alive on April 6 , 19 62 , and that death occurred at 4 M, from the causes and on the date stated above.			
22a. SIGNATURE W. Arthur Darby		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. Arthur Darby		22d. ADDRESS 817 Medical Arts Bldg Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1962	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town or county) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard Strong 3707 W. North Ave.		25a. REC'D BY REGISTRAR DATE APR 10 '62	
25b. REGISTRAR'S SIGNATURE John L. Kline			



TO HOSPITAL C. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

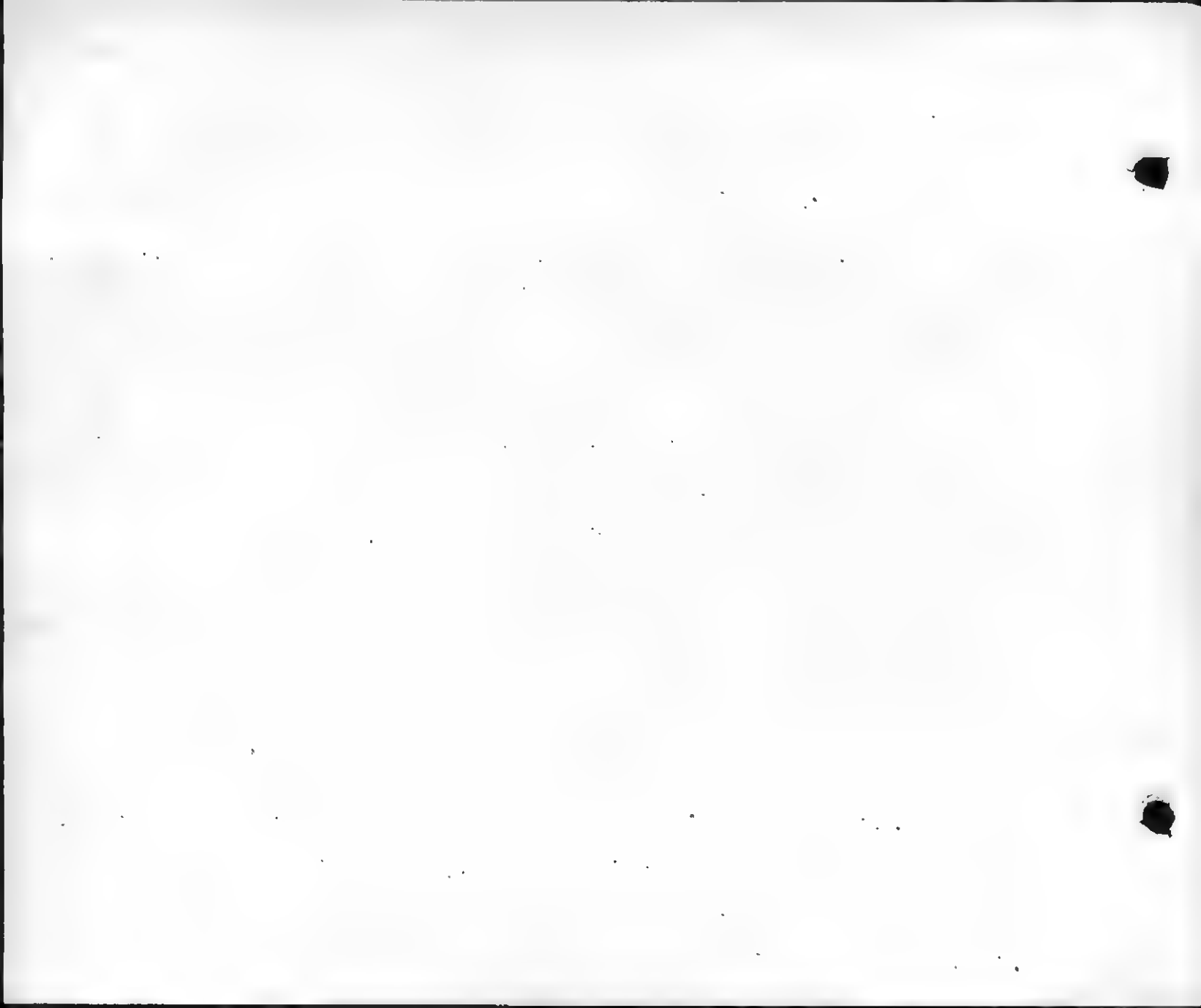
04235

CERTIFICATE OF DEATH

Reg. Dist. No.

04232

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 28</u>		c. LENGTH OF STAY IN 1b <u>21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN LINES</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE</u> Middle <u>GOLDHEIM</u> Last <u>GOLDHEIM</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>1</u> Min. <u>1</u>	
11a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>ATTORNEY</u>	
11c. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>284-10-7615</u>	
17. INFORMANT <u>BELMA ROSENBERG</u>		Address <u>903 LAKE DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>1077</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-27, 1961</u> , to <u>4-10, 1962</u> that I last saw the deceased alive on <u>4-9, 1962</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Foxfield Ave. Baltimore 28 - Md.</u> DATE SIGNED <u>4-21-62</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-13-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. HEBREW</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc - 3100 Eutanaw Place</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			



VR A15 (4)
15M 7/61

1423

04233

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>43 Fells Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES D GREENE</u>		4. DATE OF DEATH <u>April 17 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>February 17, 1891</u>	
9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Maryland</u>	
13. FATHER'S NAME <u>George Greene</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/branch of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>218-05-1120</u>	
17. INFORMANT <u>Clinical Records VAH Fort Howard, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>BILATERAL LOBAR PNEUMONIA</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Emphysema Bilateral; Pleural Adhesions Bil</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (X) (this hospital) attended the deceased from April 14, 1962 to April 17, 1962, that (X) (we) last saw the deceased alive on April 17, 1962, and that death occurred at 2:55A M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE SIGNED <u>4/17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAH Ft Howard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-20-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		23d. LOCATION (City, town or county) (State) <u>Catonsville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Higginbottom</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S NAME <u>Arthur S. Kraus</u>	



1
FOR STATE
HEALTH DEPT.

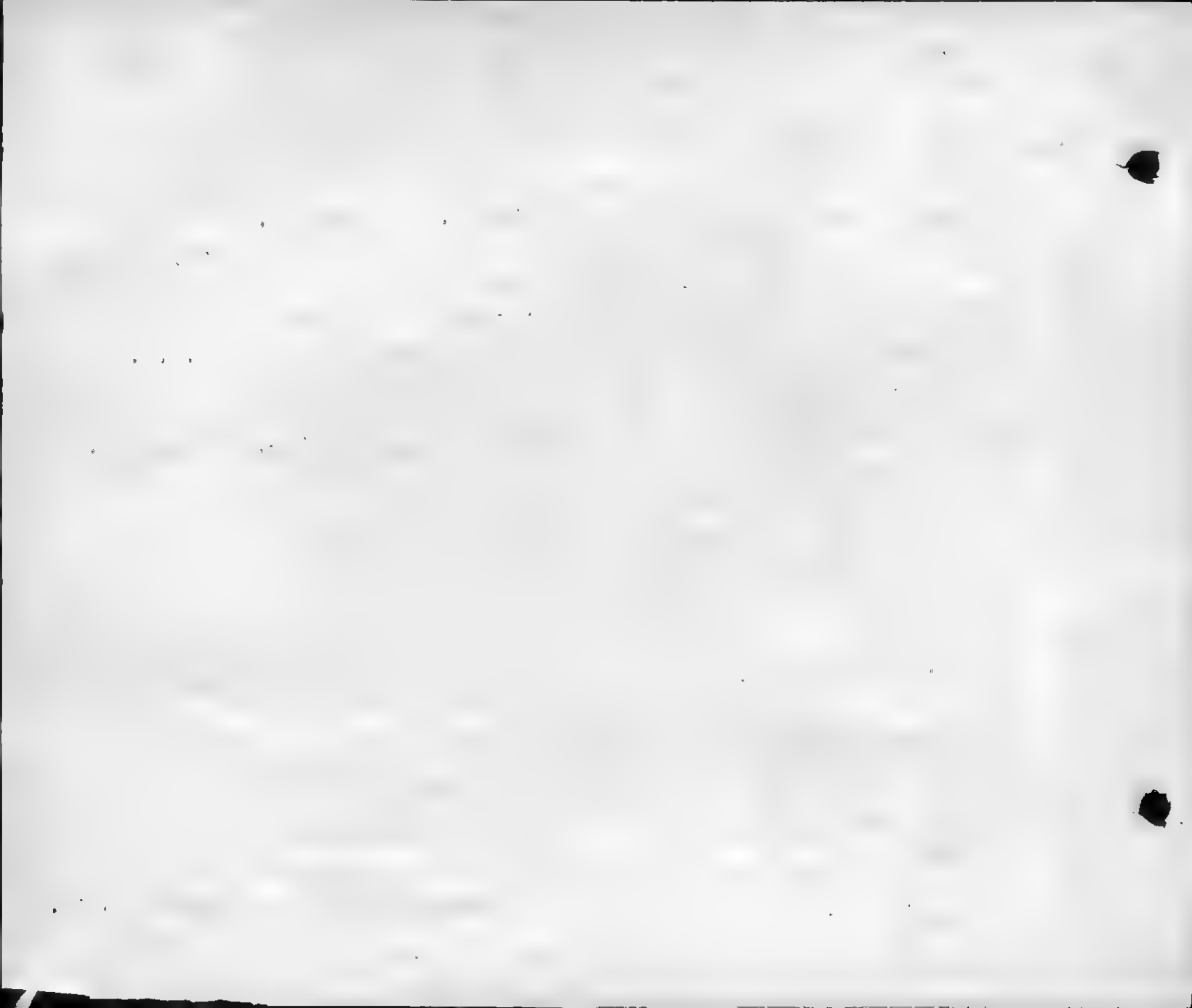
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

<p align="center">MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04234</p>									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Garrison		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Garrison Forest Road		d. STREET ADDRESS		275 S. Robinson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		FRANK KENNETH		4. DATE OF DEATH		April 21, 1962		f. AGE (in years last birthday)	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH		4-1-1921		9. AGE (in years last birthday)		41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		Gill West Virginia		12. CITIZEN OF WHAT COUNTRY?	
11. BIRTHPLACE (State or foreign country)		U.S.A.		13. FATHER'S NAME		Samuel Hager		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		Yes WW II		16. SOCIAL SECURITY NO.		Unknown		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Laceration thru Rt chest, lungs, liver Fractured upper jaw. Compound fract. of Rt. Patella Auto accident.		INTERVAL BETWEEN ONSET AND DEATH 5 min		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		None.		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran off road & struck a tree		20c. TIME OF INJURY Month, Day, Year Hour a.m. Apr 21, 1962 6:15 a.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Garrison		(County) Balto.		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		D. D. Caples		DATE SIGNED 4-21-62	
21. EXAMINER'S NAME (Type)		D. D. CAPLES		21b. ASSISTANT MEDICAL EXAMINER		21c. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		4-24		22c. NAME OF CEMETERY OR CREMATORY Ghesapeake, Ohio	
22d. LOCATION (City, town, or country)		Huntington W. Va.		23. FUNERAL DIRECTOR ADDRESS		Frank H. Newell, Pikeville 8, Md.		24a. REC'D BY REGISTRAR DATE APR 23 '62	
24b. REGISTRAR'S SIGNATURE		Arthur S. Hume		24c. REGISTRAR'S SIGNATURE		Arthur S. Hume		24d. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04238

04235

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY (in days) <u>1 yr 11 d</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>-</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> h. STREET ADDRESS <u>2244 Brookfield Avenue</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>John</u> <u>Chester</u> <u>Hamilton</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1962</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> IF UNDER 24 HRS.: Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia, -Petersburg</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Fannie ?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>unk own</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>-</u>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>-</u> p.m. <u>-</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) (County) (State) <u>-</u>													
21. I certify that (this hospital) attended the deceased from <u>April 9, 1961</u> , to <u>April 20, 1962</u> that (we) last saw the deceased alive on <u>April 20, 1962</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Loretta Y. F. Hsu</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>LORETTA Y. F. HSU</u>						22b. DATE SIGNED <u>4-20-62</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-23-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tschirch</u>						25a. REC'D BY REGISTRAR <u>APR 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL: 3. ATTENDING PHYSICIAN: The law requires that the death certificate be examined with hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



4-1
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

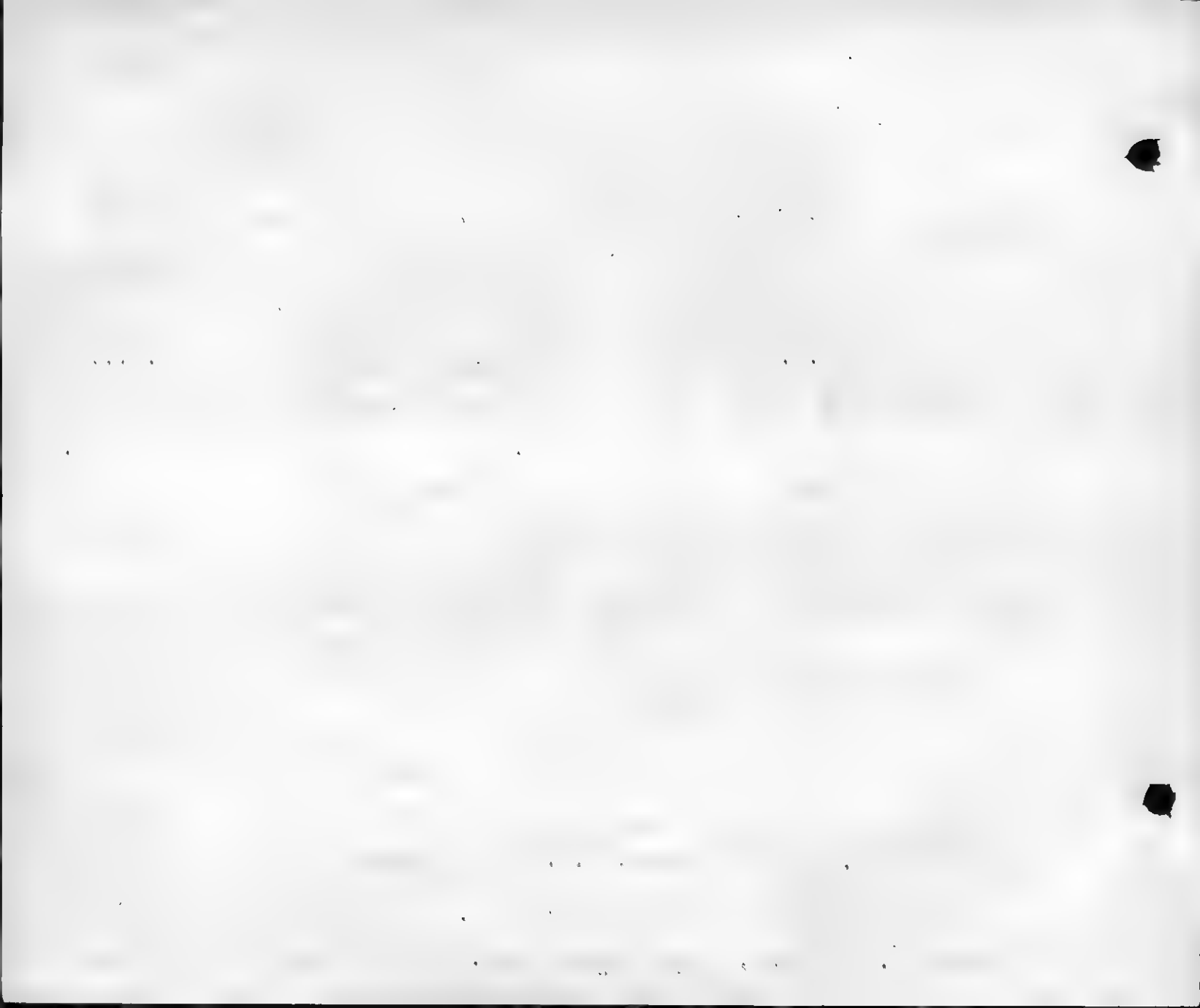
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04239

CERTIFICATE OF DEATH

04236

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8011 Temple Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>8011 Temple Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Asa Harrow Hamrick</u> 4. SEX <u>male</u> 5. COLOR OR RACE <u>white</u> 6. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <u>Nov 7, 1880</u> 8. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>01</u> Days <u>01</u> IF UNDER 24 HRS.: Hours <u>01</u> Min. <u>00</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>01</u> Days <u>01</u> IF UNDER 24 HRS.: Hours <u>01</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of workday, even if retired) <u>Retired R.R. workern</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Hamrick</u> 14. MOTHER'S MAIDEN NAME <u>Jane Baughman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO</u> 17. INFORMANT <u>Mrs. Ella Hamrick</u> Address <u>8011 Temple Ave. #14</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary of Myocard</u> 194X DUE TO (b) <u>194X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>194X</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Any</u> 20f. (City or town) <u>Any</u> (County) <u>Any</u> (State) <u>Any</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Any</u> 19 <u>61</u> , to <u>April</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1962</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>S. Elliott Harris, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>S. Elliott Harris, M.D.</u>		22b. DATE SIGNED <u>4/20/62</u> 22d. ADDRESS <u>8100 Harford Rd., Balto. 34 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/23/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u> 23d. LOCATION (City, town or county) <u>Cowen, West Virginia</u> (State) <u>West Virginia</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc., 5305 Harford Road.</u> ADDRESS <u>5305 Harford Road.</u> 25a. REC'D BY REGISTRAR <u>APR 24 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Ruck</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04240 Item 14 Film 312 5/10/62 iws											
04237											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN 1b 34 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
3. NAME OF DECEASED (Type or print) GEORGE -- HANDY						d. STREET ADDRESS 345 East Twenty-second Street					
5. SEX Male						4. DATE OF DEATH April 29 1962					
6. COLOR OR RACE Negro						7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH 10-29-91						9. AGE (In years last birthday) 70 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist						10b. KIND OF BUSINESS OR INDUSTRY Refractory					
11. BIRTHPLACE (County & State, or foreign country) Talbot County, Maryland						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Handy						14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1						16. SOCIAL SECURITY NO. 218-10-6628					
17. INFORMANT Clin Rec VAH Fort Howard Maryland						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26, 1962 to April 29, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 29, 1962 , and that death occurred at 7:03 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo											
22b. DATE SIGNED 4-30-62											
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.											
22d. ADDRESS VAH, Fort Howard, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 5-4-62											
23c. NAME OF CEMETERY OR CREMATORY Baltimore National											
23d. LOCATION (City, town or county) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Adolphus Talstead, 918 Druid Hill Ave. Baltimore, Md.											
25a. REC'D BY REGISTRAR MAY 1 1962											
25b. REGISTRAR'S SIGNATURE Arthur J. Kautz											

14

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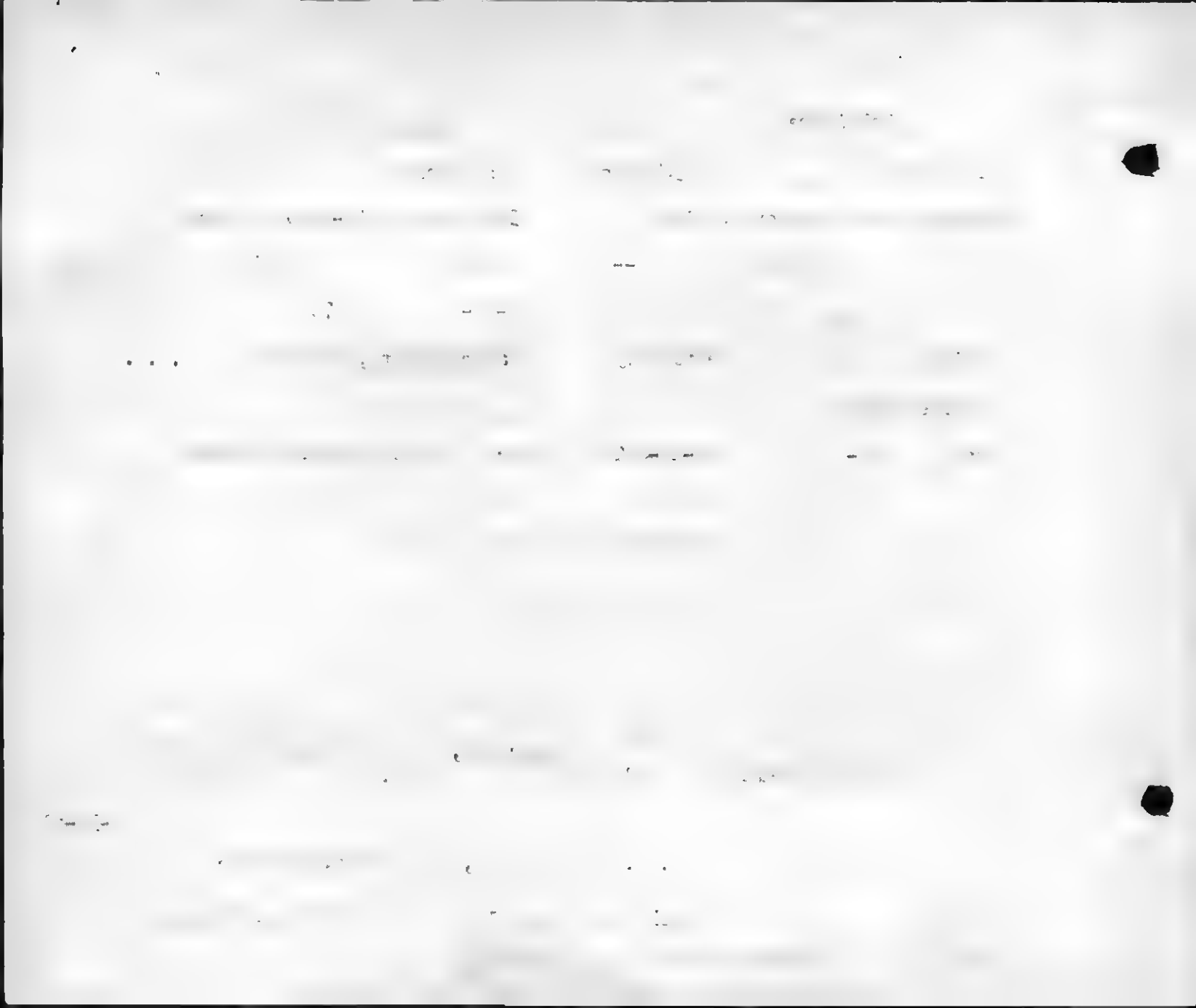
2

301-4

o. IS RESIDENCE ON A FARM? YES ☐ NO ☒

INTERVAL BETWEEN ONSET AND DEATH **UNKNOWN**

UNKNOWN



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE HEALTH DEPT. (M)
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04241 04238

1. PLACE OF DEATH
 a. COUNTY **Baltimore** b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Mt. Washington** c. LENGTH OF STAY IN b. **MARYLAND**
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **1204 Fairfield Avenue**

2. USUAL RESIDENCE (Where deceased lived, if not list one; Residence if not in residence)
 a. STATE **Maryland** b. COUNTY **Baltimore** c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Mt. Washington** d. STREET ADDRESS **1204 Fairfield Avenue** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type, or print) **WILLIAM EARLE HARRIS** 4. DATE OF DEATH **April 16 1962**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH **March 6, 1896** 9. AGE (In years last birthday) **66** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Automobile Mechanic** 10b. KIND OF BUSINESS OR INDUSTRY **Maryland** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **William T. Harris** 14. MOTHER'S MAIDEN NAME **Delia Lawrence**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **Yes WW I** 16. SOCIAL SECURITY NO **213 01 2129** 17. INFORMANT **Harold J. MacMillan, 1314 Appleby Ave., Balto. 9** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Asphyxia from massive hemorrhage of Carcinoma of throat**
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **14' CX** DUE TO (b) **Sudden**
 DUE TO (c)
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)

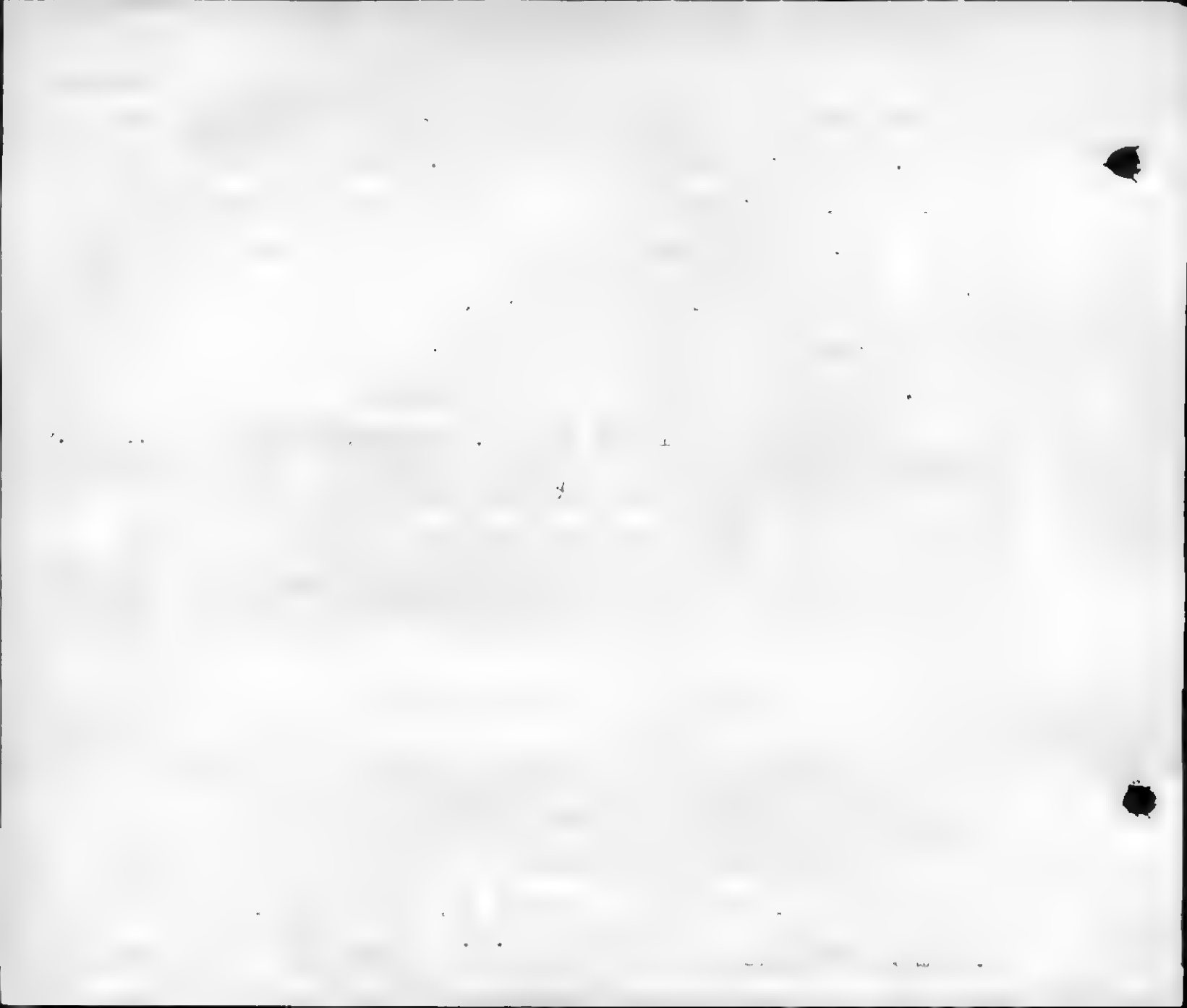
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles F. O'Donnell** M.D. CHIEF MEDICAL EXAMINER ☐
 EXAMINER'S NAME (Type) **Charles F. O'Donnell** ASSISTANT MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **4/16/62**
 Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **April 19, 1962** 22c. NAME OF CEMETERY OR CREMATORY **Baltimore National Cem.** 22d. LOCATION (City, town, or country) **Baltimore Co., Maryland** (State)

23. FUNERAL DIRECTOR **Burgee Funeral Home** ADDRESS **3631 Falls Rd Balto. Md.** 24a. REC'D BY REGISTRAR **APR 18 '62** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

By: **Norace K. Surger**



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

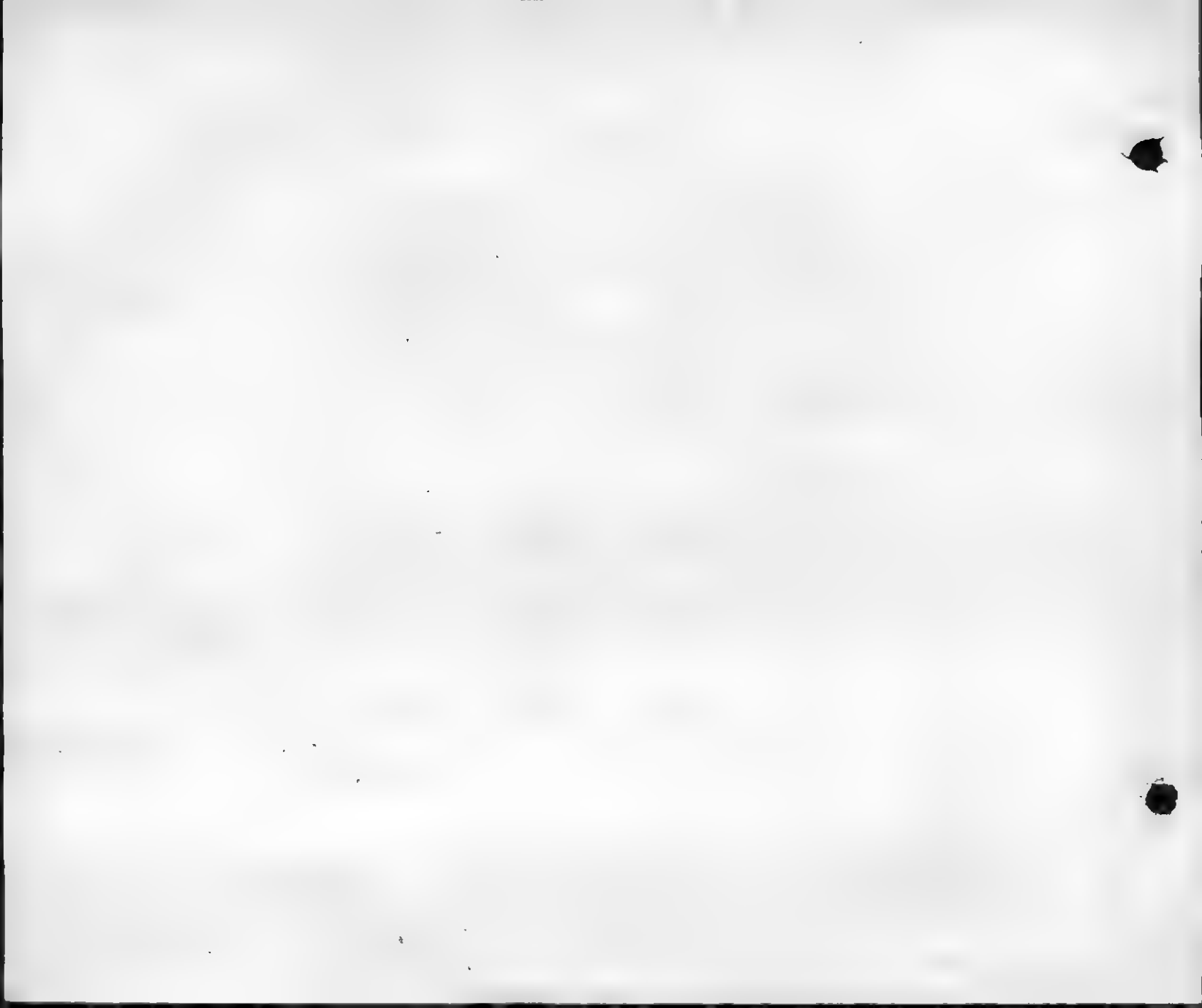
CERTIFICATE OF DEATH

04242

04239

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>115 BEAUMONT AVE</u>				d. STREET ADDRESS <u>115 BEAUMONT AVE</u>			
3. NAME OF DECEASED (Type or print) <u>ALICE MOULTON HAYNES</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 18, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William B. Moulton</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Callio</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give name and date of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Isabelle Hasky</u>				Address <u>115 Beaumont Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> (b) <u>Carcinoma of Breast</u> (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <u>None</u>							
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 9, 1952</u> to <u>April 24, 1962</u> that (I) (we) last saw the deceased alive on <u>April 24, 1962</u> , and that death occurred at <u>4:45 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Grabill</u>				22b. DATE SIGNED <u>APR 30 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>James R. GRABILL, M.D.</u>				22d. ADDRESS <u>5550 Balto Nat'l Pike</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-27-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		23d. LOCATION (City, town or county) <u>Balto.</u> (State) <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home - Catonsville, Md.</u>				25. REG'D BY REGISTRAR DATE <u>APR 30 1962</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04243

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04210

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b. <u>7mth 15days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkridge, Maryland</u> d. STREET ADDRESS <u>4950 Tulip Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>L. B.</u> Last <u>Heron</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> , Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neumonia</u> DUE TO (b) <u>Abscess of Parotid gland (left)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Chronic Brain Syndrome assoc with Cerebr. Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (X) (this hospital) attended the deceased from <u>Aug. 24, 1961</u> to <u>April 24, 1962</u> that (I) (we) last saw the deceased alive on <u>April 24, 1962</u> , and that death occurred at <u>7:05 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga</u> M.D. <u> </u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town or county) <u>Elkridge, Howard Co., Md.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>XXXXXX</u> ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Avenue #29</u>		25a. REC'D BY REGISTRAR <u>APR 27 '62</u> DATE <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			



13
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, removal, and in any event within 72 hours after death.

(M)

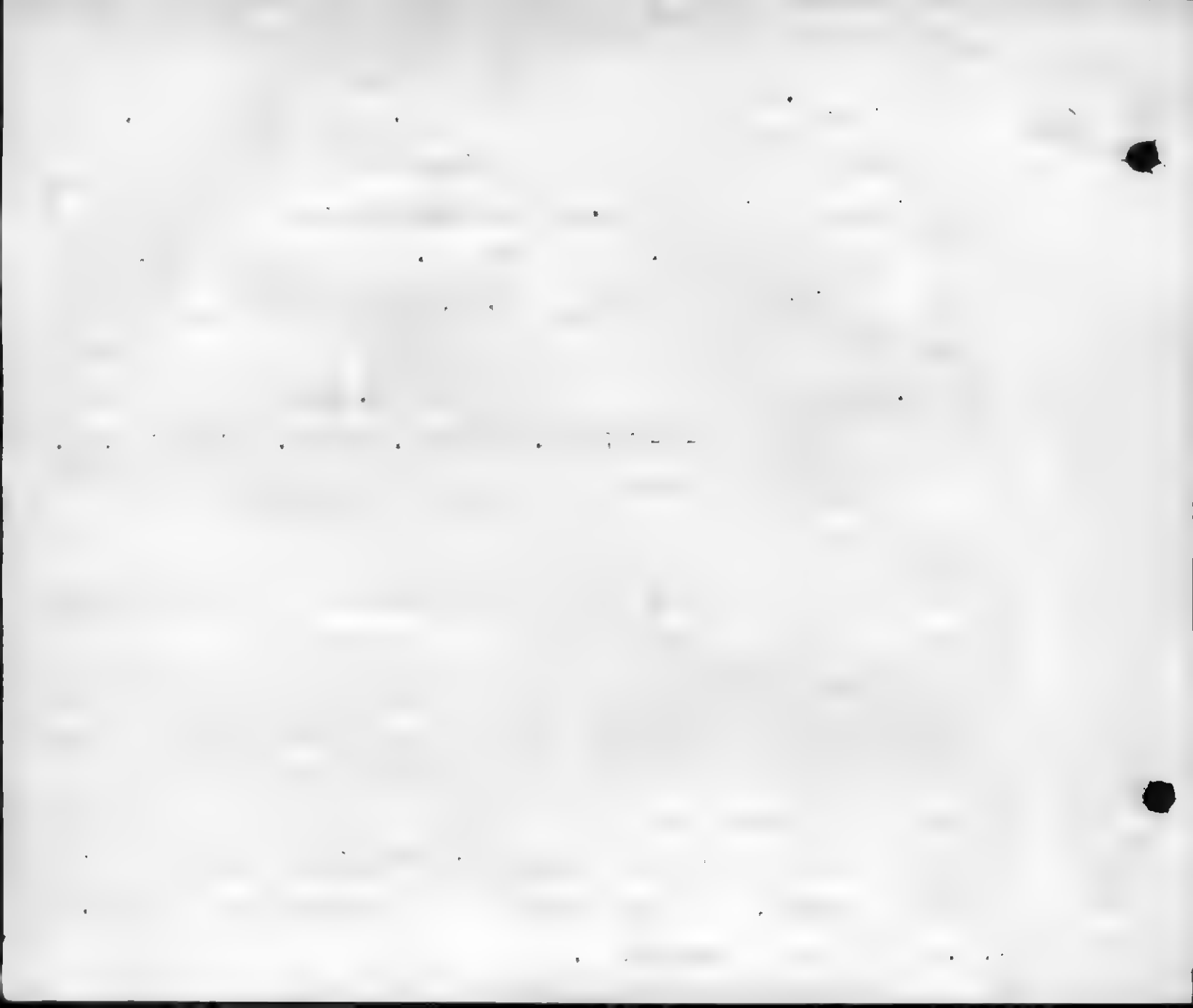
X

(M)

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04241

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cherry Hill Lane & Reisterstown Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Benjamin H. Higgs Sr.				4. DATE OF DEATH April 27, 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 24, 1894	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		11. IF UNDER 24 HRS. Hours <input type="checkbox"/> M n. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jacob T. Higgs				14. MOTHER'S MAIDEN NAME Barbara L. Painter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-12-3167			
17. INFORMANT Mr. Benjamin H. Higgs Jr.				Address Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 5 min.?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) D. D. Caples, M. D. 6 Hanover Rd., Reisterstown, Md. 4-28-62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 30, 1962		22c. NAME OF CEMETERY OR CREMATORY Good Shephard	
22d. LOCATION (City, town, or country) (State) Ellicott City Md.							
23. FUNERAL DIRECTOR J. F. Eline & Sons				24a. REC'D BY REGISTRAR DATE MAY 1 '62			
ADDRESS Reisterstown, Md.				24b. REGISTRAR'S SIGNATURE Carlton L. Kline			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04245 CERTIFICATE OF DEATH 04242

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6917 Ridgeway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>6917 Ridgeway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR D. HILL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman-ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Byron F. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Estes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Arthur J. Alfeld 6917 Ridgeway</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4-30-62</u> DUE TO <u>Arterio Sclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED <u> </u> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 26, 1962</u> to <u>Apr 30, 1962</u> that (I) (we) last saw the deceased alive on <u>Apr 26, 1962</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Stephen L. Mackowick</u> M.D.	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN L. MACKOWICK</u>		22b. DATE SIGNED <u> </u>	
22d. ADDRESS <u>6714 Hocoland Ave Baltimore Md.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 1, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthew's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>St. Louis, Missouri</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home Dundalk, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. <u> </u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04246

04243

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Cockeysville</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Holland</u>				d. STREET ADDRESS <u>1825 Bolton St.</u>			
4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1962</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 18, 1881</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		13. FATHER'S NAME <u>James C Pringle</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Morris</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Md Masonic Home - Cockeysville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - hyper tension</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiac or aortic disease</u> (c) <u></u> (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1962</u> to <u>April 22, 1962</u> ; that (I) (we) last saw the deceased alive on <u>April 22, 1962</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Elizabeth B Shorrell</u> M.D.				22b. DATE SIGNED <u>4/22/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B Shorrell</u> MD				22d. ADDRESS <u>Cockeysville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>				25a. REC'D BY REGISTRAR <u>DATE 4-24-62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

VR A15 (4)
15M 9/60



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(4)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04247 CERTIFICATE OF DEATH 04244

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P 14 in</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN it		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wright Care Nursing Home</u>		d. STREET ADDRESS <u>3411 Rolling Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>R.</u> Last <u>Hook</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1962</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Mrs. Blanche East-418 Stratford Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>422. DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u> (c) <u>BRONCHITIS - PNEUMONITIS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>62</u> to <u>4/21</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>62</u> , and that death occurred at <u>6:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u> M.D.		22b. DATE SIGNED <u>4/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>		22d. ADDRESS <u>5500 Edmonson Ave. Dr. 18, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hgts. Avenue</u>		25a. REC'D BY REGISTRAR <u>DATE APR 25 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			



1
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

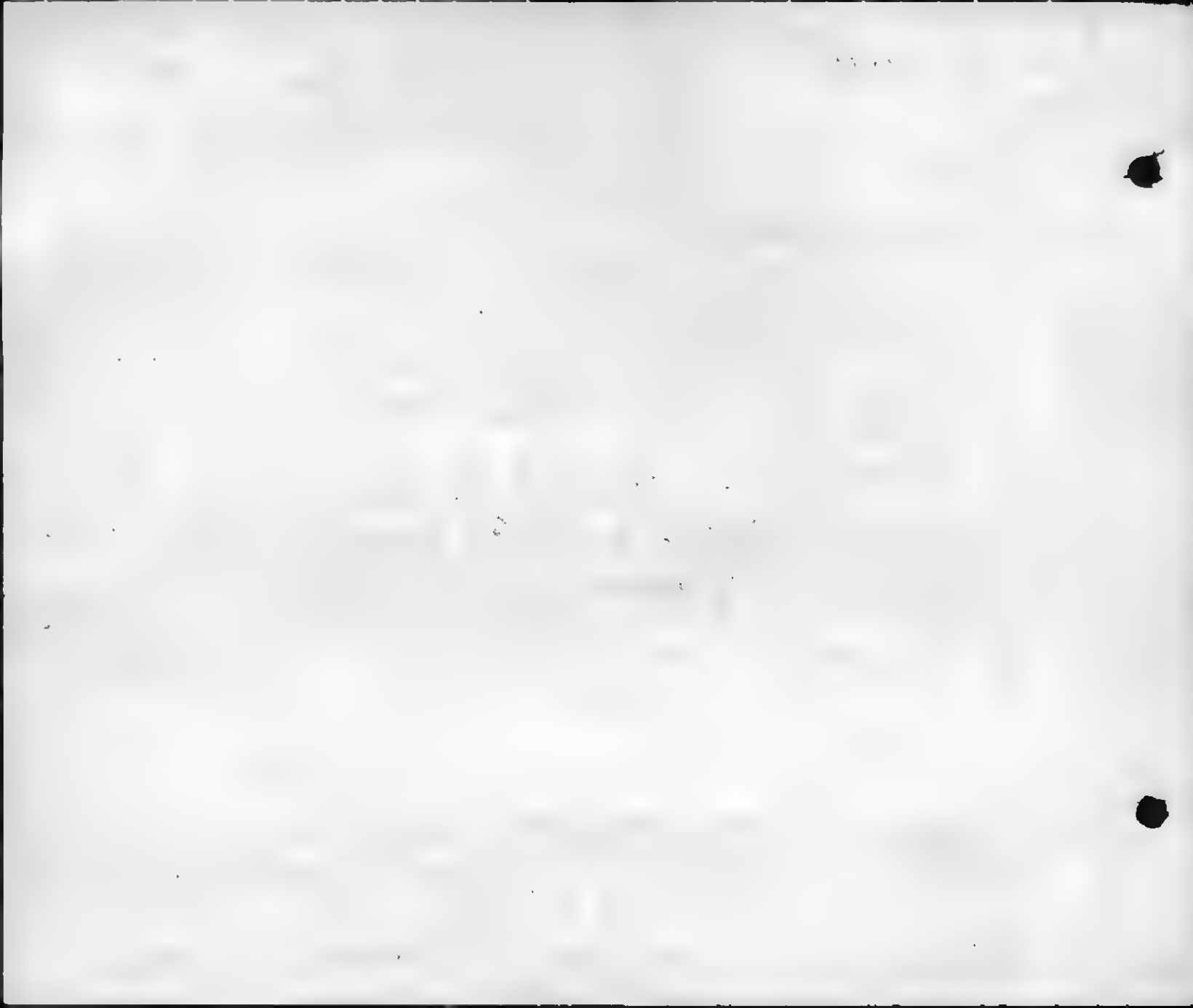
CERTIFICATE OF DEATH

04248

Items 1c & 4 Film 0311 4/24/62 mh

04245

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN IL 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 405 East Fort Avenue	
3. NAME OF DECEASED (Type or print) Allen George Allen Hook		4. DATE OF DEATH April 12, 1962	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Hook		14. MOTHER'S MAIDEN NAME Katherine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular (c) Disease		INTERVAL BETWEEN ONSET AND DEATH Hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from April 5, 1962 to April 12, 1962 , that (I) (we) last saw the deceased alive on April 12, 1962 , and that death occurred at 5:28 PM from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Cruzaga, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SPRING GROVE STATE HOSP.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town or county) (State) Balto 25 MD.	
24. FUNERAL DIRECTOR'S SIGNATURE My Cully		25a. REC'D BY REGISTRAR APR 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. ADDRESS 130 S. Fort Ave. 30	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

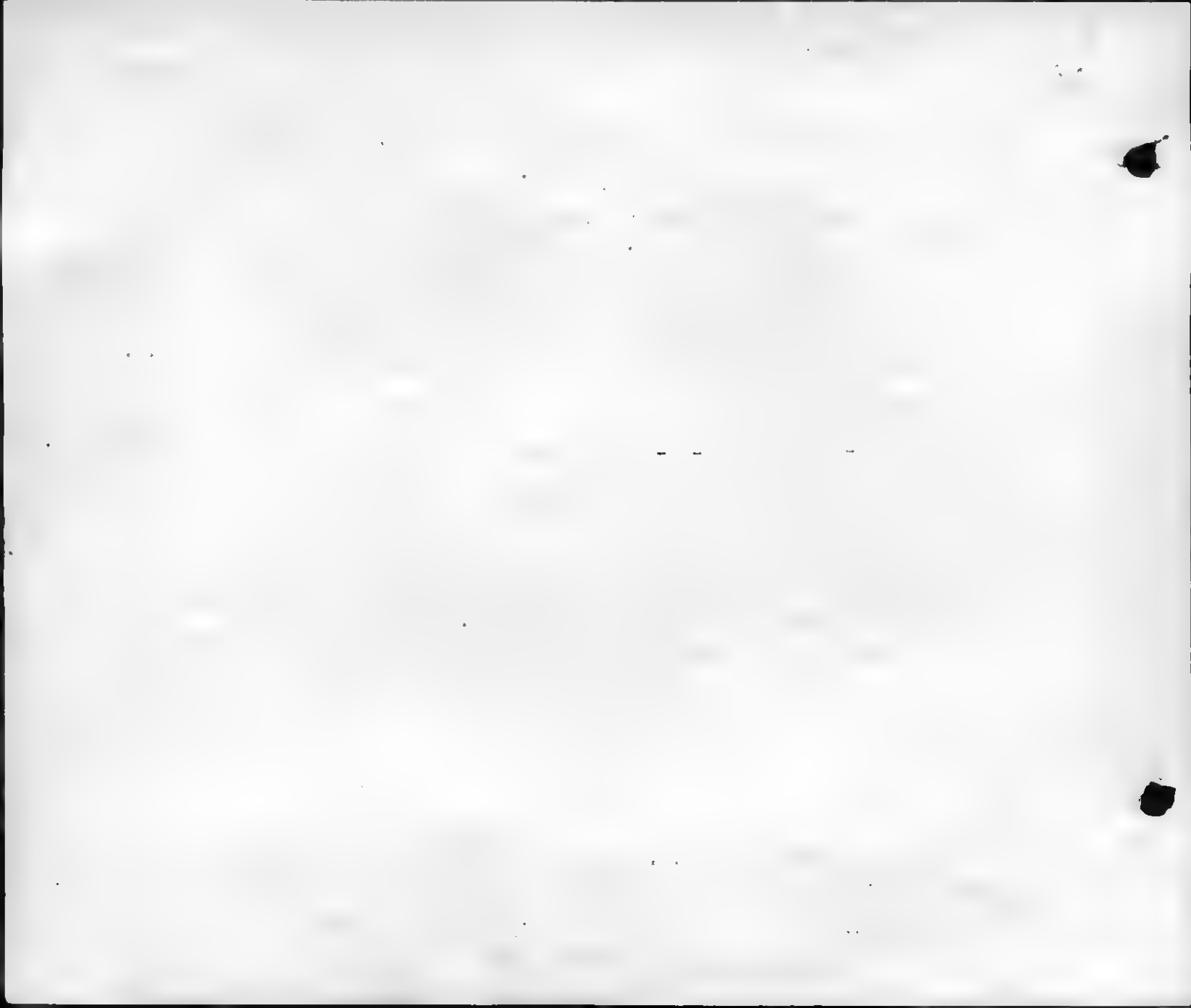
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04249

04246

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>3 Hours 45 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>Box 123 RFD 4</u>	
3. NAME OF DECEASED (Type or print) <u>Served as: DAVID W. HOOPER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 16, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reese Hooper</u>		14. MOTHER'S MAIDEN NAME <u>Alice Haines</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO. <u>215-18-1423</u>	
17. INFORMANT <u>Clinical Records, VA Hospital, Fort Howard, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peritonitis secondary to Appendiceal Abscess. Pneumonia.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>N</u> (this hospital) attended the deceased from <u>April 27, 1962</u> to <u>April 27, 1962</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>April 27, 1962</u> , and that death occurred at <u>4:15</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/28/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSHUA SMITH, M.D.</u>		22d. ADDRESS <u>VA Hospital, Fort Howard, Maryland</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/1/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethany Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Faylarsville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Westminster Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>MAY 1 '62</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

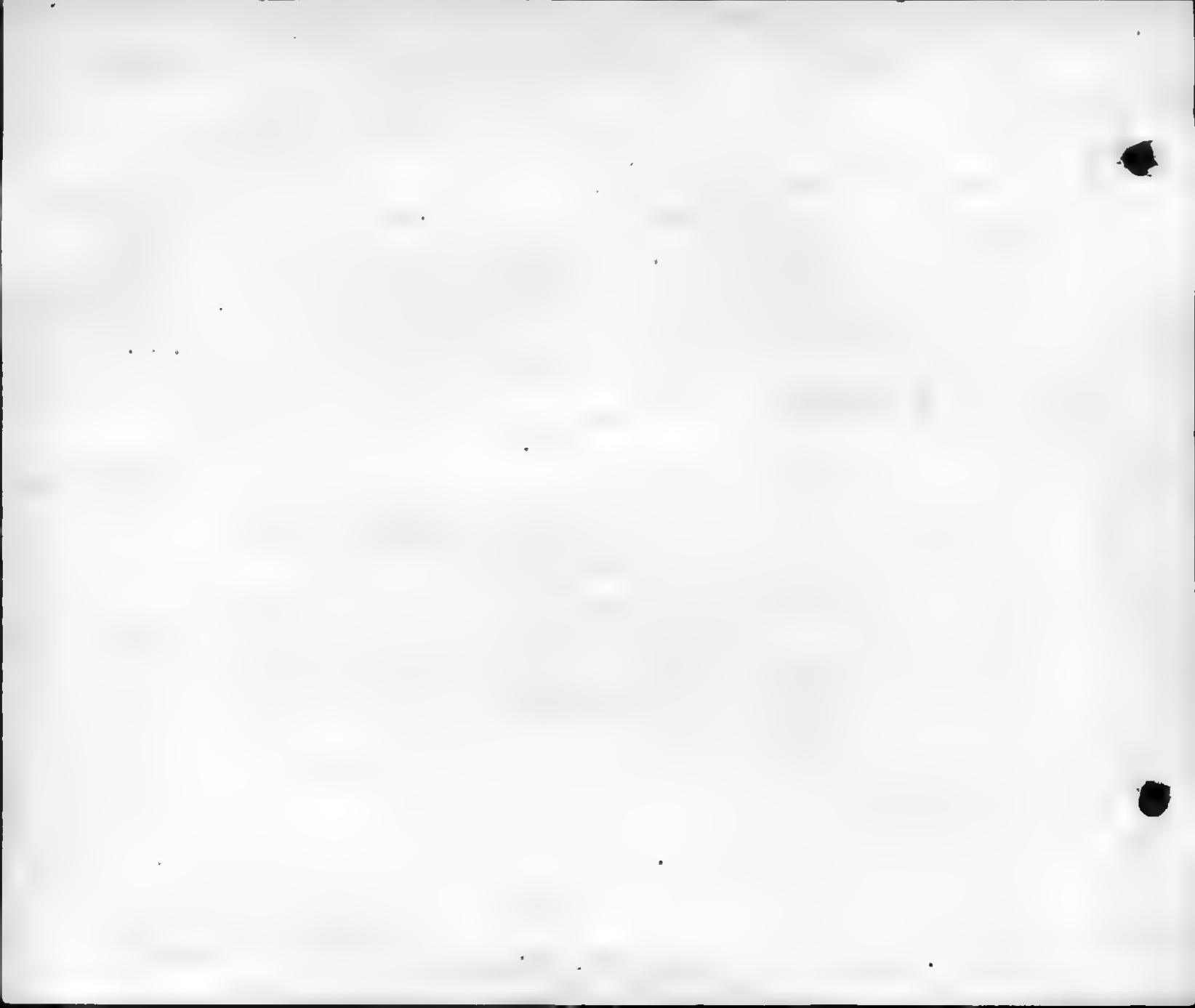
04250

CERTIFICATE OF DEATH

04247

Item 4 Film 0515 5/10/62 jwl

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY in lb <u>5 Days</u>		d. STREET ADDRESS <u>612 W. LaFayette Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>P.</u> Last <u>HOWARD</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/2/25</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Howard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Griggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Clin.Rec.VAH, Fort Howard, Maryland</u>	
17. INFORMANT <u>Clin.Rec.VAH, Fort Howard, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO 441X Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE (MALIGNANT NEPHROSCLEROSIS)</u> (c) <u>NEPHROSCLEROSIS</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL MONTHS</u> <u>SEVERAL MONTHS</u>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from <u>4/17/1962</u> to <u>4/22/1962</u> , that (I) (we) last saw the deceased alive on <u>4/22/1962</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Joshua D. Smith</u> M.D. 22b. DATE SIGNED <u>4/22/62</u> 22c. PHYSICIAN'S NAME (Type) <u>JOSHUA SMITH, M.D.</u> 22d. ADDRESS <u>VA HOSPITAL, FORT HOWARD, MD.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/26/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1000 Brantley Ave Baltimore 17, Maryland</u> 25a. REC'D BY REGISTRAR <u>APR 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04248

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			c. LENGTH OF STAY IN It <u>2001-4</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box # 150 Forge Rd.</u>			d. STREET ADDRESS <u>332 Folcroft St. # 24</u>										
3. NAME OF DECEASED (Type or print) <u>GERTRUDE BARBARA HUBER</u>			4. DATE OF DEATH <u>April 30 19 62.</u>										
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>										
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Dec. 28, 1910</u>										
9. AGE (In years last birthday) <u>51</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS											
Months	Days	Hours	Min.										
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>										
13. FATHER'S NAME <u>Casper Fischer</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Lindenberger</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>-----</u>										
17. INFORMANT <u>John Louis Huber</u>			Address <u>Same.</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of gall bladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____													
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____									
20f. (City or town) _____		(County) _____		(State) _____									
21. I certify that (I) (this hospital) attended the deceased from <u>Febr. 14, 1962</u> to <u>April 30, 1962</u> that (I) (we) last saw the deceased alive on <u>April 30, 1962</u> and that death occurred at <u>6:25 P.M. EDT</u> from the cause and on the date stated above.													
22a. SIGNATURE <u>Theodore E. Evans</u>			22b. DATE SIGNED <u>5/2/62</u>										
22c. PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M. D.</u>			22d. ADDRESS <u>9660 Belair Rd. Balto 36, Md.</u>										
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-3-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery 7501 German Hill Rd., Md.</u>									
23d. LOCATION (City, town or county) <u>Balto., Md.</u>		23e. (State) <u>Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Gailer</u>			25a. REC'D BY REGISTRAR <u>MAY 3 '62</u>										
25b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>			25c. ADDRESS <u>6224 Eastern Ave. Balto., Md.</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01249

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY BALTIMORE ✓ 345 WHITRIDGE AVE.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUMMIT NURS. HOME.		d. STREET ADDRESS 345 WHITRIDGE RD.	
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE HUDSON		4. DATE OF DEATH Month Day Year APR. 4, 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 15, 1883
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY D.H.	
11. BIRTHPLACE (State or foreign country) IRELAND.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME HURLEY		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. WILLIAM H. HUDSON (SON) 1226 CEDARCROFT RD., BALTO., MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, 4 2. DUE TO Anterior chest / heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 5 + yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anterior chest. CERVICAL POLYS-REMOVED 28 MAR 1962.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 March 1962 to 4 April 1962 that I last saw the deceased alive on 4 April 1962 , and that death occurred at 1:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6348 FREDERICK RD BALTO. MD. DATE SIGNED 4 April 1962			
ACTUAL SIGNATURE John N. Snyder		PHYSICIAN'S NAME (Type) JOHN N. SNYDER M.D. BALTIMORE 28, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/7/62	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.		24a. REC'D BY REGISTRAR DATE APR 5 1962	
24b. REGISTRAR'S SIGNATURE Clara P. Hume			



TO HOSPITAL OR CLINIC PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

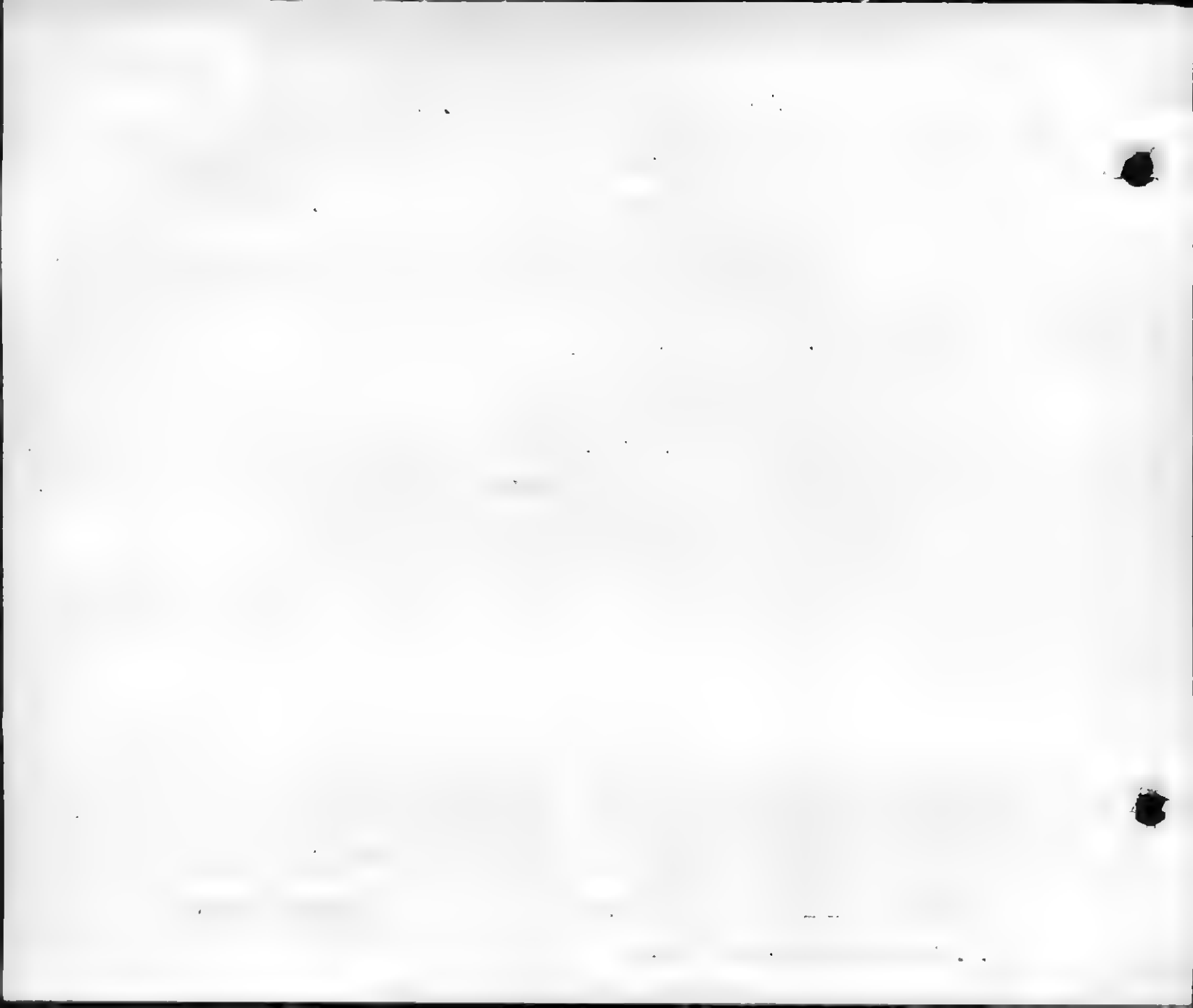
04253

04250

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOGWOOD Rd - BOT 1961		d. STREET ADDRESS BOT 1961 - DOGWOOD Rd	
3. NAME OF DECEASED (Type or print) CHARLES HENRY HUMPHREY		4. DATE OF DEATH Month 4 Day 29 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER		10b. KIND OF BUSINESS OR INDUSTRY GARDENER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HUMPHREY		14. MOTHER'S MAIDEN NAME —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 216-07-4010	
17. INFORMANT MR. LUTHER HUMPHREY - DOGWOOD PL - BALTO. 7, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DEGENERATIVE HEART DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE C.V. DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 5, 1950 to APRIL 29, 1962 , that (I) (was) last saw the deceased alive on APRIL 24, 1962 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Edwin L. Pierpont, M.D.		22b. DATE SIGNED 4/29/62	
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.		22d. ADDRESS 8704 LIBERTY Rd - BALTO. 7, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-2-62	
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City, town, or county) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR MAY 1 '62 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. House	

(M)

(I)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04251

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7874 Elmhurst Ave.</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Md.</u> b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville - Baltimore</u></p> <p>d. STREET ADDRESS <u>2855 Westfield Ave.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Isabella M. Hupfeld</u></p> <p>4. DATE OF DEATH <u>4/19/62</u></p> <p>5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Sept 9, 1908</u></p> <p>8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 9. AGE (In years - If under 1 year, if under 24 hrs. last birthday) <u>50</u> Months Days Hours Min.</p> <p>10. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>Gustaf Giesecke</u> 14. MOTHER'S MAIDEN NAME <u>Lena Seebode</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>1220-30-1404 B.</u> 17. INFORMANT <u>Mrs. Henry C. Hupfeld</u> Address <u>same.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cardiac & renal vascular disease</u></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b)</p> <p>causing the underlying cause last. (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>8 wks</u></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		<p>20c. TIME OF INJURY Month, Day, Year <u>19</u></p> <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (th's hospital) attended the deceased from <u>1958</u> to <u>ap. 19, 1962</u>, that (I) (we) last saw the deceased alive on <u>ap. 17, 1962</u> and that death occurred at <u>5P.</u> M, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>Harold H. Burns</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u></p>		<p>22b. DATE SIGNED <u>ap. 19-62</u></p> <p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p> <p>22d. ADDRESS <u>8106 Harford Rd. Maryland</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>23b. DATE THEREOF <u>4/23/62</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u></p> <p>23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u></p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Nuck Inc.</u> ADDRESS <u>5305 Harford Rd.</u></p>		<p>25a. REC'D BY REGISTRAR <u>APR 24 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u></p>	

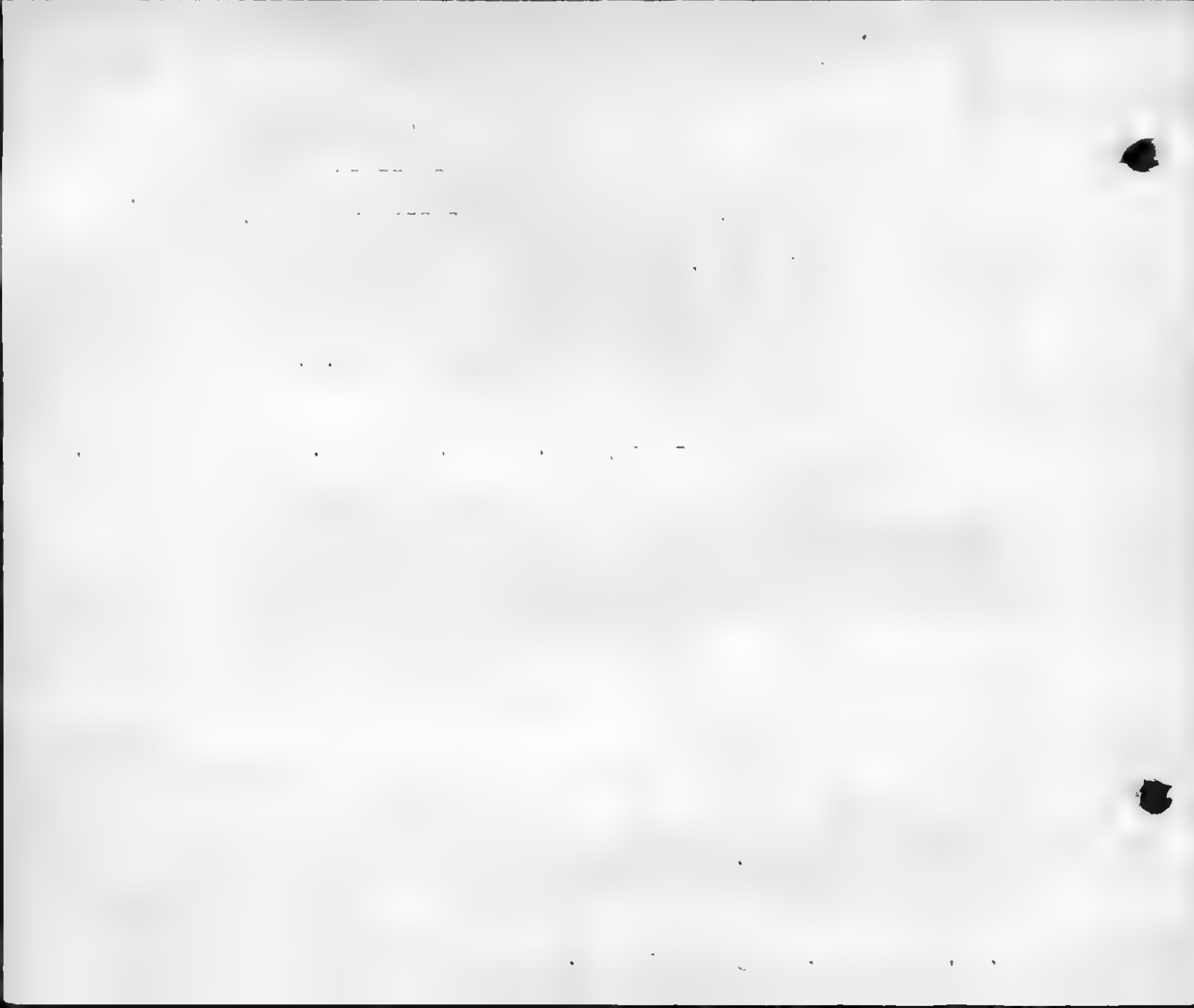
16

04254

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MEDICAL CERTIFICATION



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04255

04252

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>24 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>11 Cemetery Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>Leroy</u> Last <u>HURLOCK</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>September 9, 1915</u>	
9. AGE (In years last birthday) <u>46 yrs.</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	
11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Preston, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hurlock</u>		14. MOTHER'S MAIDEN NAME <u>Ida F. Blades</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218-03-5903</u>	
17. INFORMANT <u>Clinical Records Veterans Adm. Hosp. Ft Howard, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA RIGHT LUNG WITH METASTASES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>XXXXX TO THORACIC WALL AND DIAPHRAGM</u>		(b) <u>PNEUMONIA, BILATERAL</u>	
(c) <u>DUE TO</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>6:45</u> a.m. <u>6:45</u> p.m.		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>March 26, 1962</u> <u>April 19, 1962</u>	
21. I certify that (X) (this hospital) attended the deceased from <u>March 26, 1962</u> <u>6:45 P</u> to <u>April 19, 1962</u> that (X) (we) last saw the deceased alive on <u>April 19, 1962</u> and that death occurred at <u>6:45 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAN F. HOWARD, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d. LOCATION (City, town or county) <u>Hurlock, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Framptom and Son, Federalsburg, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>C. L. S. Frank</u>			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04256 CERTIFICATE OF DEATH 04253

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS Route 2	
3. NAME OF DECEASED (Type or print) Michael Eugene HYSER 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent 10b. KIND OF BUSINESS OR INDUSTRY none		8. DATE OF BIRTH 8/12/61 9. AGE (in years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) 8 yrs. 8 Months 8 Days 0 Hours 0 Mins. 11. BIRTHPLACE (County & State, or foreign country) Gettysburg, Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Leroy Hyser 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Betty Fogle (Hyser) Address Rosewood Records, Owings Mills, Maryland.		18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aspiration pneumonia 75°x DUE TO Inhalation of food Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Hydrocephalic condition DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus communicating type (Birth)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12 April 1962 20f. (City or town) 20 April 62 (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 12 April 1962 to 20 April 62 , that (I) (we) last saw the deceased alive on 20 April 1962 , and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Harry G. Butler M.D. 22b. PHYSICIAN'S NAME (Type) Harry G. Butler		22c. DATE 20 April 62 22d. ADDRESS Taneytown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF April 22, 1962 23c. NAME OF CEMETERY OR CREMATORY Piney Creek Presbyterian Cem. Taneytown, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S NAME (Type) W. J. Fessler ADDRESS Taneytown Md.		25a. REC'D BY REGISTRAR APR 23 '62 25b. REGISTRAR'S SIGNATURE W. J. Fessler	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04254

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 11 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 2 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 716 Aisquith St. d. STREET ADDRESS 716 Aisquith St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First -- Middle Ingram Last		4. DATE OF DEATH April 27 19 62 Month Day Year	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 3, 1890 yrs. Months Days	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b. AGE (in years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Elec. Instrument Co. (Retired)	
11. BIRTHPLACE (County & State, or foreign country) Lunenburg Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Anthony Ingram		14. MOTHER'S MAIDEN NAME Hester Stokes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-10-1846	
17. INFORMATION Clinical Records, VAH, Fort Howard, Maryland Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) DIABETES MELLITUS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 16, 1962 , to April 27, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 27, 1962 , and that death occurred at 9:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan, M.D.		22b. DATE 4/27/62	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, Fort Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		25a. REC'D BY REGISTRAR MAY 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 1000 Brantley Avenue Baltimore 17, Maryland	



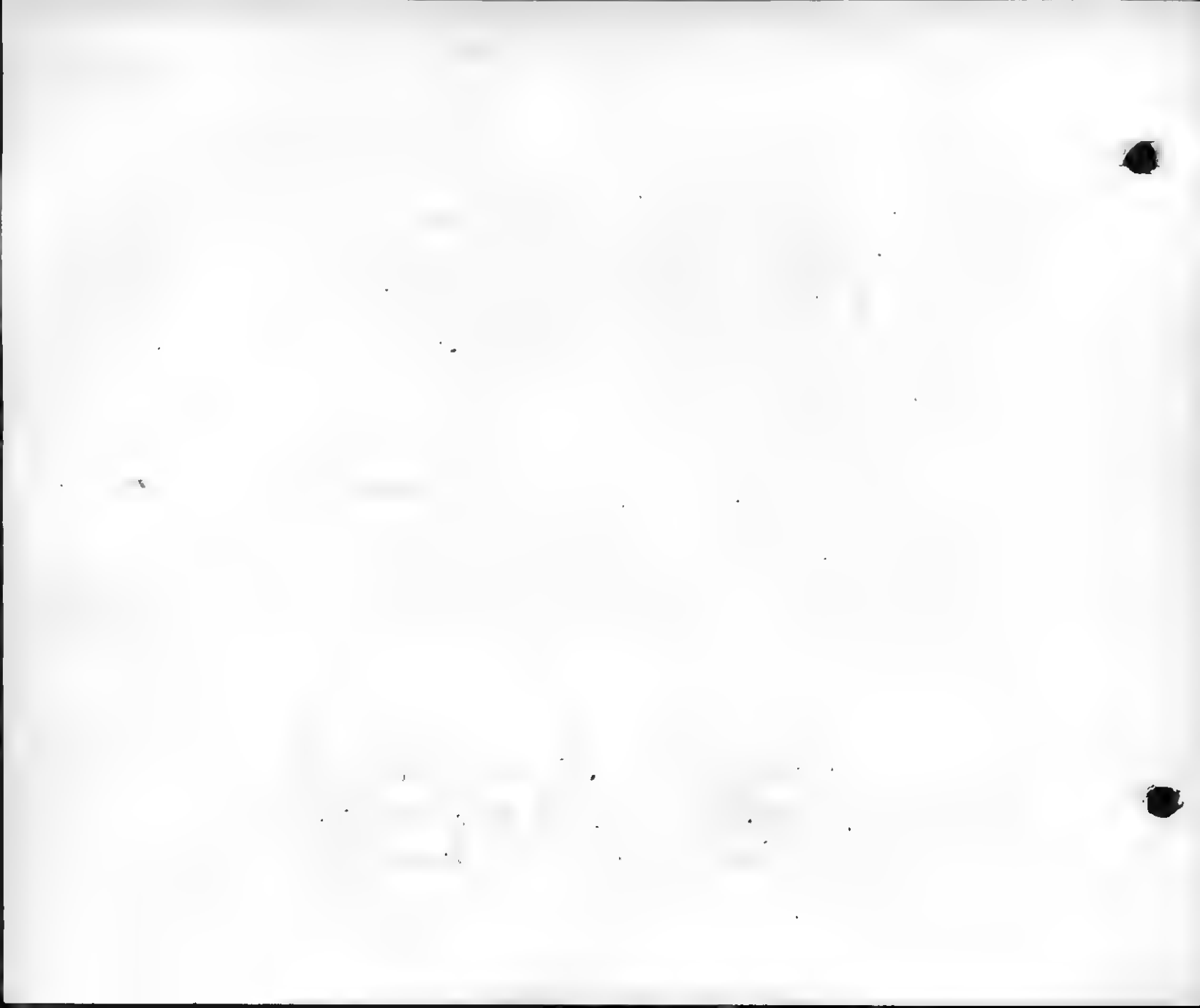
04258

CERTIFICATE OF DEATH

Reg. Dist. No. 04255

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKDALE</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LIBERTY COURT REHABILITATION CENTER</u>		d. STREET ADDRESS <u>5417 LYNVIEW AVE</u>	
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First Middle Last <u>ISEKOFF</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1899</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>MAX ISEKOFF</u> Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>199X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan, 1962</u> to <u>April 24, 1962</u> that I last saw the deceased alive on <u>4-28-1962</u> and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Deckerbaum, M.D.</u>		ADDRESS (Street, city or town, state) <u>5401 Old Court Rd. Rockdale</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH DECKERBAUM, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/1/1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eutan Pl.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04260						04257					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				a. STATE		b. COUNTY			
BALTO.		Catonville				MD.		BALTO.			
c. LENGTH OF STAY IN b.		8 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
1312 Zugwell Ave						1312 Zugwell Ave					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Edward L. Jacobs						April 9, 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Male		W.		NEVER MARRIED		Oct. 2, 1887		74 yrs.		IF UNDER 24 HRS.	
				WIDOWED						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Clerk				BALTO. Gas & Elec. Md				USA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Charles E. Jacobs						Amelia Hoffman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.					
						2/3-03-8704-Mrs. Elsie Jacobs (same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:						36 hrs					
IMMEDIATE CAUSE (a)						3 yrs					
527.1 DUE TO						undet.					
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
(c)											
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED					
Hour a.m. p.m.						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 3, 1962 to April 9, 1962, that (I) (we) last saw the deceased alive on April 7, 1962, and that death occurred at 11 AM, from the causes and on the date stated above.						22b. DATE SIGNED					
22a. SIGNATURE						22c. ADDRESS					
Bradley Dougherty M.D.						4-10-62					
22c. PHYSICIAN'S NAME (Type)											
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
Burial						4/12/62					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City, town or county) (State)					
Western						BALTO. MD					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
Witice F. H. 4101 Edmondson						DATE APR 12 '62					
						25b. REGISTRAR'S SIGNATURE					
						Arthur S. Thomas					



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

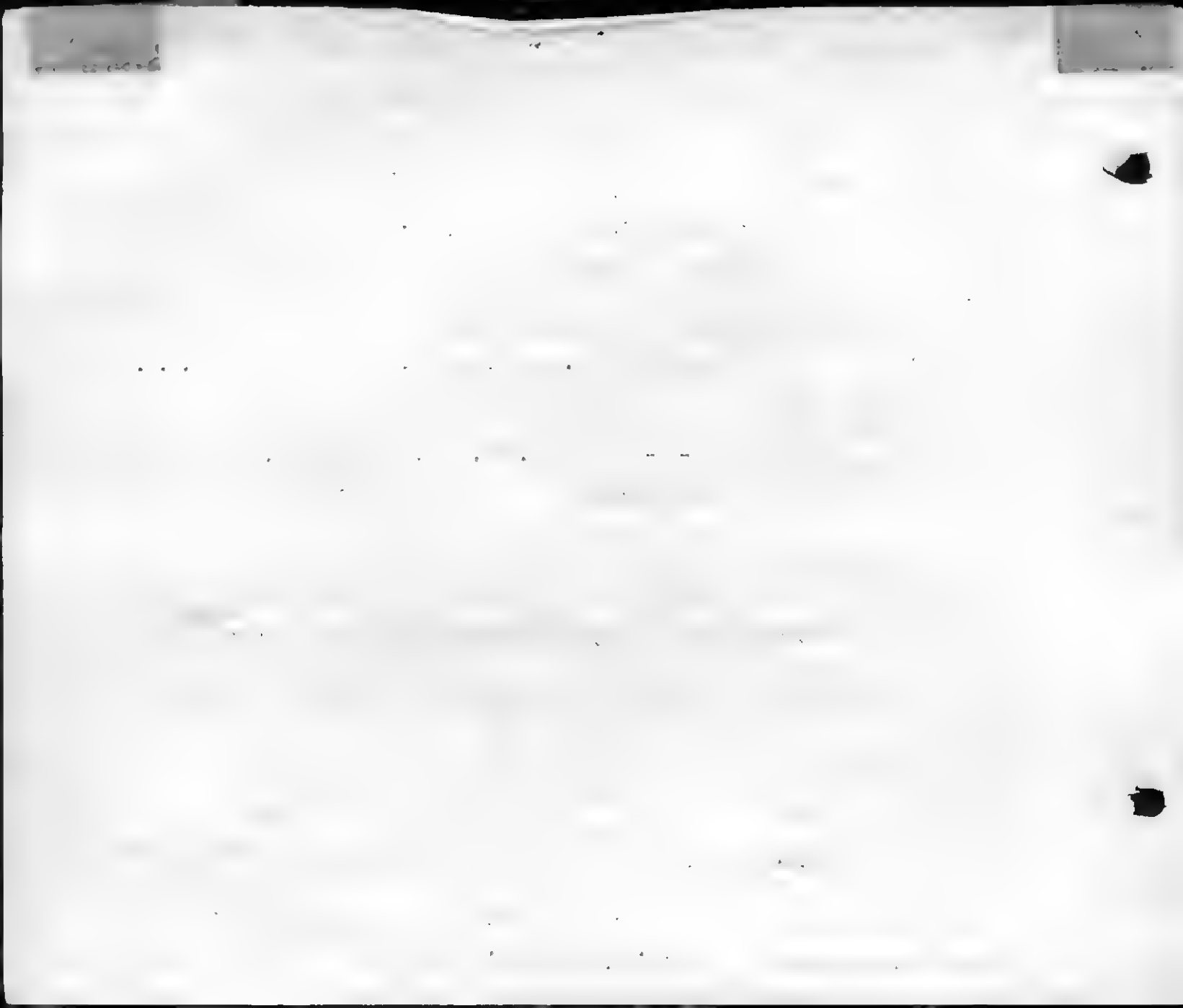
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04258

04258

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN IL 13 Days		d. STREET ADDRESS 1409 E. Lafayette Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLETCHER Middle (NMI) Last JACOBS		4. DATE OF DEATH Month APRIL Day 9 Year 19 62	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/27/05	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Rubber Tire Co.	
11. BIRTHPLACE (County & State, or foreign country) Live Oak, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jacobs		14. MOTHER'S MAIDEN NAME Cora Bush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 719-10-0077	
17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) MYOCARDITIS 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Hypostatic Bronchopneumonia, right; Pheochromocytoma left adrenal			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 3/27 to 4/9 , 1962, that (we) last saw the deceased alive on 4/9 , 1962, and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Sebastian Russo</i>		22b. DATE SIGNED 4/10/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elliott Funeral Home		25a. REC'D BY REGISTRAR APR 11 '62	
ADDRESS 1129 N. Caroline St. Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE <i>Wm. L. Thomas</i>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04259

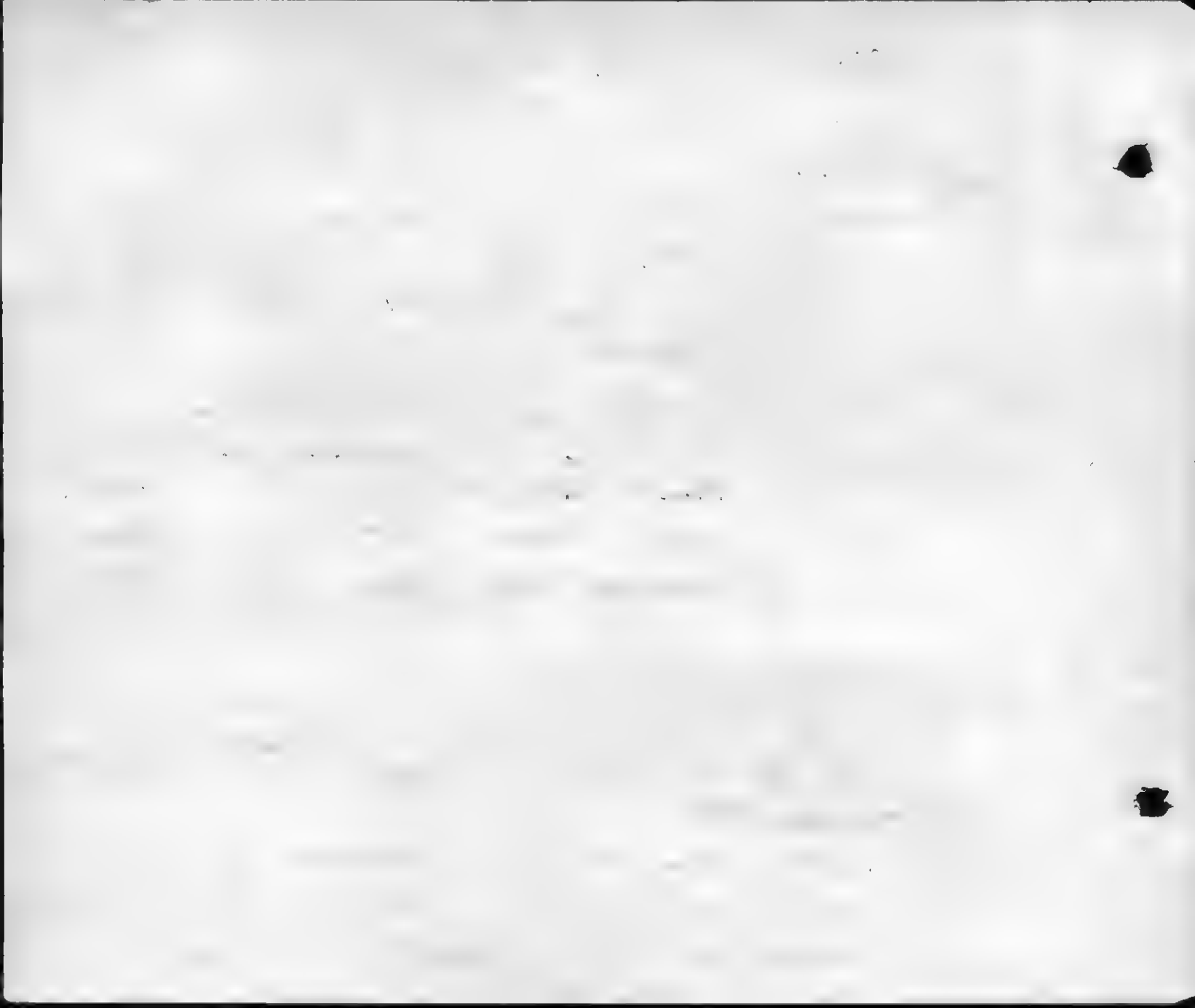
04256

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 BEACHWOOD AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>9 BEACHWOOD AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF (Type or print) <u>ANNIE VIRGINIA JOHNSON</u>		4. DATE OF DEATH <u>APRIL 17 1962</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 26 1870</u>		9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR: Months <u>9</u> Days <u>2</u> Hours <u>1</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENN.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George E. Early</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rittner</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>George B. Johnson - 9 Beachwood Ave</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pruritic - Dermatitis</u> DUE TO (b) <u>Angina Pectoris - Severe</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>36 yrs</u> <u>4 mos</u> <u>4 years</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from <u>19 30</u> to <u>April 17, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1962</u> , and that death occurred at <u>8:30 P</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Wetherbee Fort</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u> 22d. ADDRESS <u>6 Sutton Ave. Catonsville. 28. Md.</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>4-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cm.</u>				23d. LOCATION (City, town or county) (State) <u>Woodlawn Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home - Catonsville</u>				25a. REC'D BY REGISTRAR <u>APR 23 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Chas S. Harris</u>									

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MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04262

04259

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3 STANLEY DRIVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u> d. STREET ADDRESS <u>13 STANLEY DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ADAH D JOHNSON</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</u> Year <u>1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/18/93</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Drostrow</u>				14. MOTHER'S MAIDEN NAME <u>Kauffman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Family records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative C.V. D C Failure</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ASCD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-4-62</u> to <u>4-6-62</u> that (I) (we) last saw the deceased alive on <u>4-6-62</u> and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James B. Howard</u>				22b. DATE SIGNED <u>4-7</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Catonville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>4/9/62</u>		<u>Lorraine Park</u>		<u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Macnab & Son</u>				25a. REC'D BY REGISTRAR DATE <u>APR 9 '62</u>			
<u>301 Frederick</u> <u>Balto. 28 Md</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL:

VR A15 (4)
15M 9/60

04263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04260

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wright Care and Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u> d. STREET ADDRESS <u>1 South Beechwood Avenue #28</u>	
3. NAME OF DECEASED (Type or print) <u>Alfred Jones</u> 4. DATE OF DEATH <u>April 13, 1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 23, 1881</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Scranton, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John S. Jones</u> 14. MOTHER'S MAIDEN NAME <u>Margaret ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>140-20-0100</u> 17. INFORMANT <u>Mr. Robert A. Jones-1 South Beechwood Ave.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC C.V.D.</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> 19 <u>62</u> to <u>4/13</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/13</u> 19 <u>62</u> and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John A. Shaw</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN A. SHAW M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/13/62</u> 22d. ADDRESS <u>5500 EDWARDS AVE. BALTIMORE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE THEREOF <u>4-14-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washburn Street Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Scranton, Pennsylvania</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tuckner</u> ADDRESS <u>North & Pa Ave Balt</u> 25. REC'D BY REGISTRAR <u>APR 16 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William J. Tuckner</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

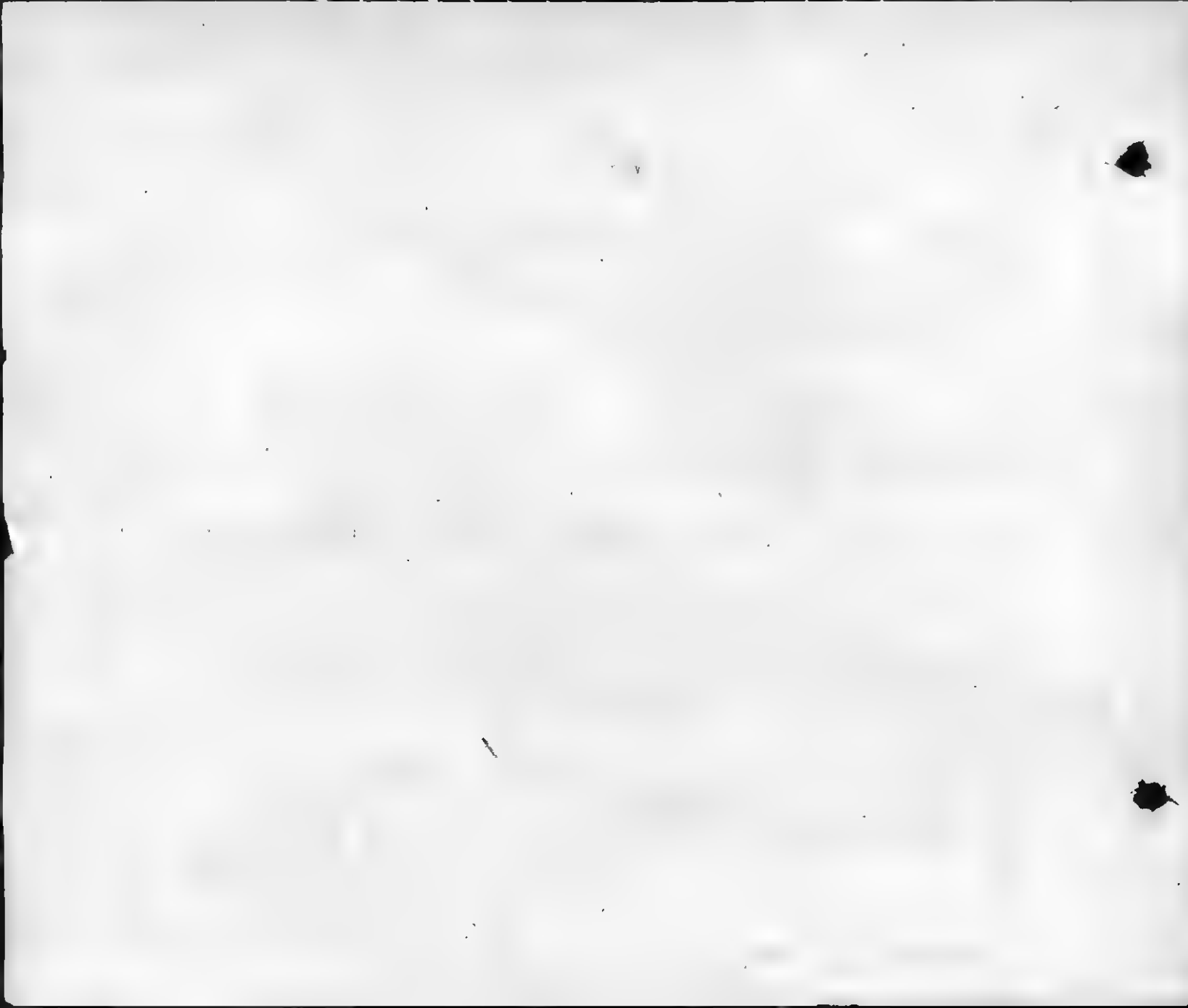
CERTIFICATE OF DEATH

04264

04261

Item 2 Film G512 5/7/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Balto</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ivy Hall Nursing Home</u>			d. STREET ADDRESS <u>19 Harrison Avenue</u>		
3. NAME OF DECEASED (Type or print) <u>Edith</u>			4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1962</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>4-17-1879</u>		
9. AGE (in years last birthday) <u>83</u> yrs.			10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Unknown Smith</u>			14. MOTHER'S MAIDEN NAME <u>Edith Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Mr Charles Jones</u>			Address <u>4214 E. Joppa Road (36)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4-30 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>62</u> to <u>4/30</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>62</u> , and that death occurred at <u>2:25</u> P.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>G.M. Baumgardner</u>			22b. DATE SIGNED <u>4/30/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>G.M. Baumgardner</u>			22d. ADDRESS <u>Balto 6 Md</u>		
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5-3-1962</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Bradshaw Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassalle Funeral Home</u>			25a. REC'D BY REGISTRAR <u>DATE MAY 2 '62</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

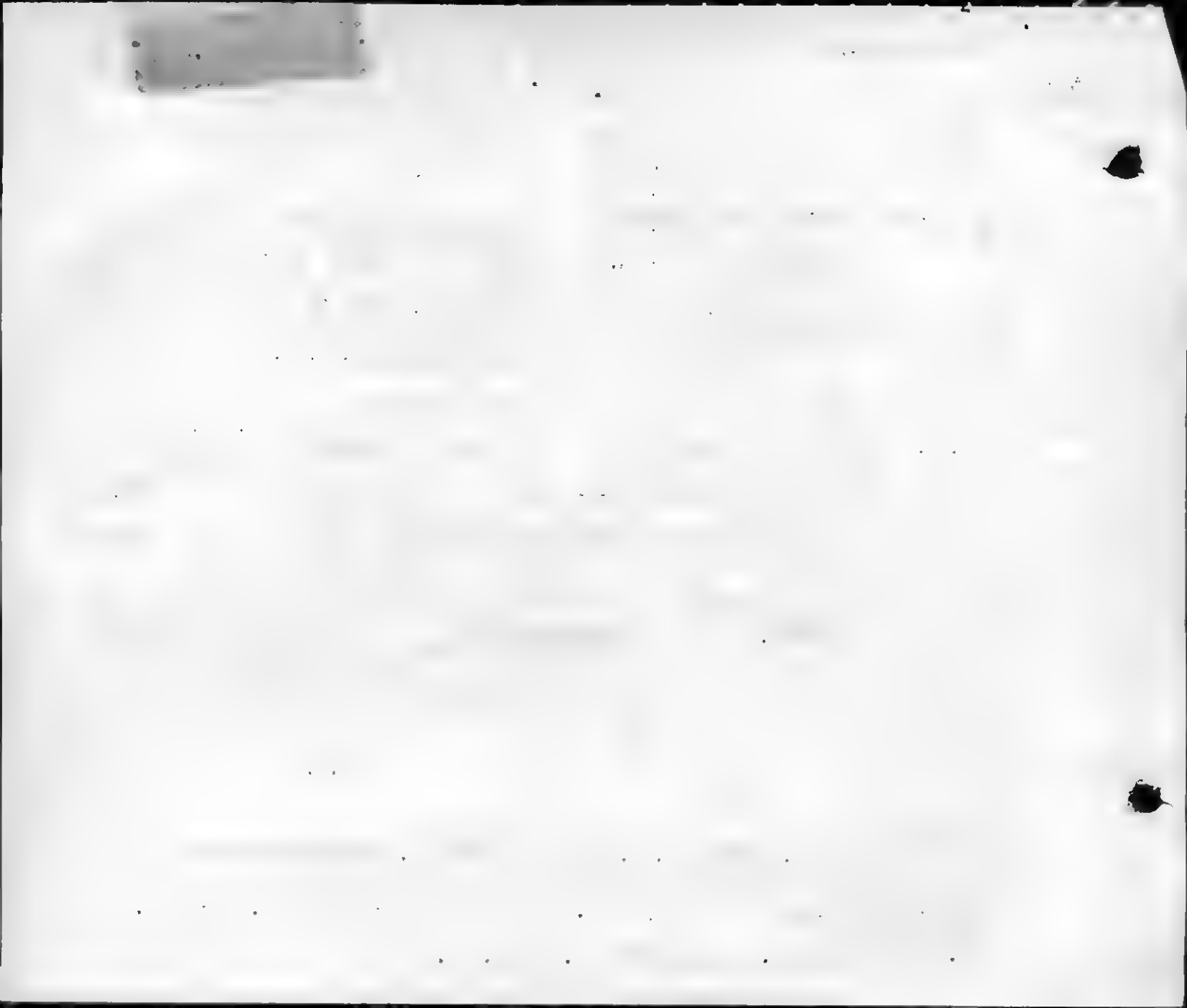
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04265

04262

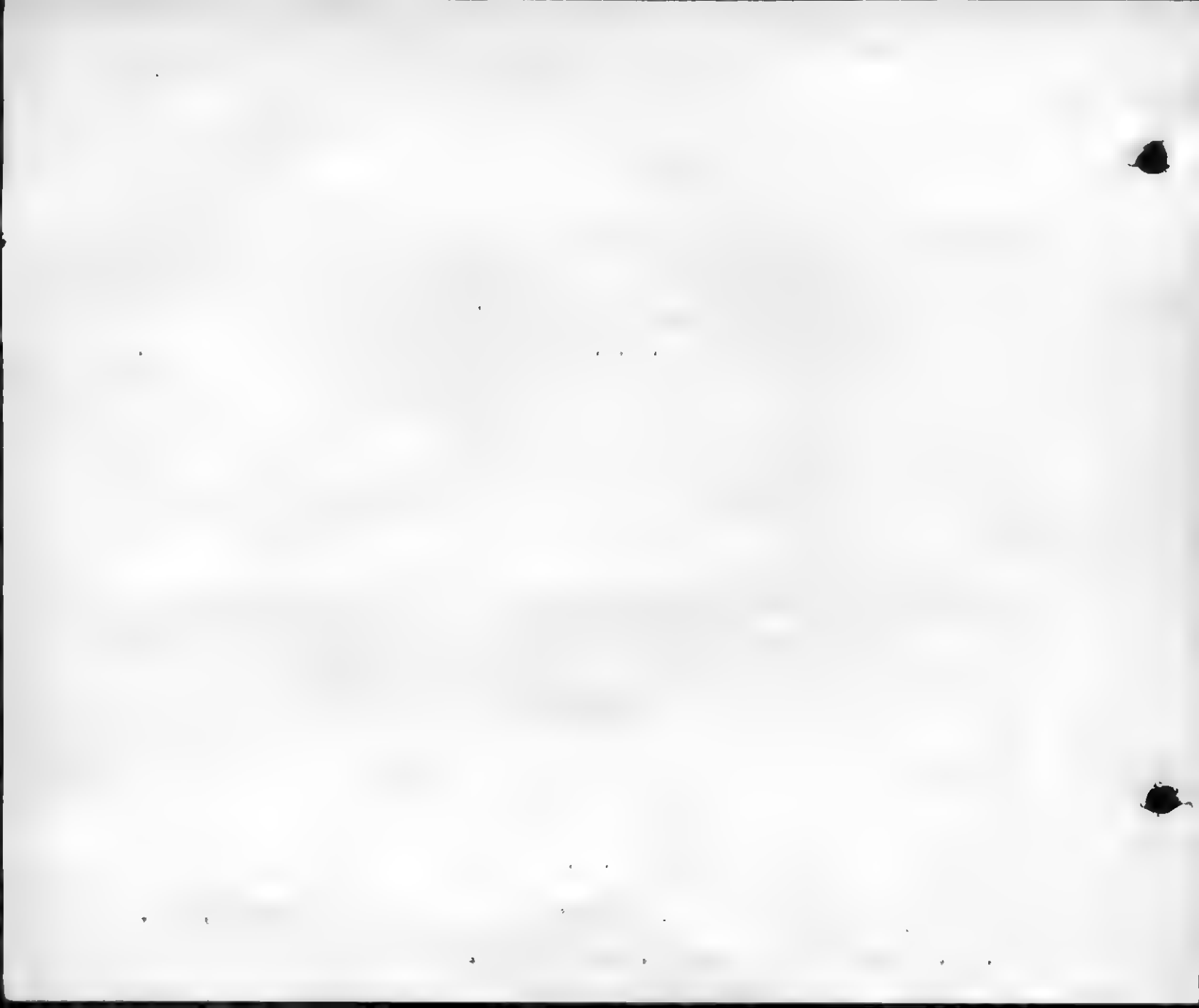
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 77 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital								d. STREET ADDRESS 1733 Park Avenue					
3. NAME OF DECEASED (Type or print) ALAN R. KELLEY				4. DATE OF DEATH April 26 1962				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory				11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Kelley				14. MOTHER'S MAIDEN NAME Mary Turnbaugh									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 212-03-4264		17. INFORMANT Clinical Records, VA Hospital Fort Howard, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4 PULMONARY INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
PULMONARY EMPHYSEMA. ENCEPHALOMALACIA													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 62				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from February 8, 1962, to April 26, 1962, that (I) (we) last saw the deceased alive on April 26, 1962, and that death occurred at 10:30 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Thomas F. Crahan M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/26/62					
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M. D.				22d. ADDRESS VAH, FT. HOWARD, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-30-62				23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery				23d. LOCATION (City, town or county) (State) Balto. Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. Balto. Md.				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04266
04263

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b Hyrlmthocys				d. STREET ADDRESS 131 Augusta Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL							
3. NAME OF DECEASED (Type or print) James Francis Kelly				4. DATE OF DEATH Month April Day 17 Year 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS. Hours 19 Min. 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auditor				10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME James Kelly				14. MOTHER'S MAIDEN NAME Maggie Ryan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown				16. SOCIAL SECURITY NO. 218-14-7190		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 720							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from March 11, 1958 to April 17, 1962 that (H) (we) last saw the deceased alive on April 17, 1962 and that death occurred at 7:45 M. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-17-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/19/62		23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTIMORE, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. W. MEARS & SON 805 N. CALVERT ST.				25a. REC'D BY REGISTRAR APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04267

CERTIFICATE OF DEATH

04264

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN <u>lb</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>113 Charmuth Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>113 Charmuth Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles David Kephart</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 6, 1920</u>			
9. AGE (In years, last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Burton Kephart</u>					
14. MOTHER'S MAIDEN NAME <u>Lelia Yount</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u> </u>							
17. INFORMANT Address <u>Lutherville</u> <u>Mrs. Martha Kephart, 113 Charmuth Rd., Maryland</u>							
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>426-1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>April 10, 1962</u> that (I) (we) last saw the deceased alive on <u>April 10, 1962</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Gilmore</u>				22b. DATE SIGNED <u>4/12/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>George T. Gilmore, M.D.</u>				22d. ADDRESS <u>Lanham Building Lutherville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/13/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery Taneytown, Maryland</u>			
23d. LOCATION (City, town or county) <u> </u>		(State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Shiles</u>		25a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

MISSARY, Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director.

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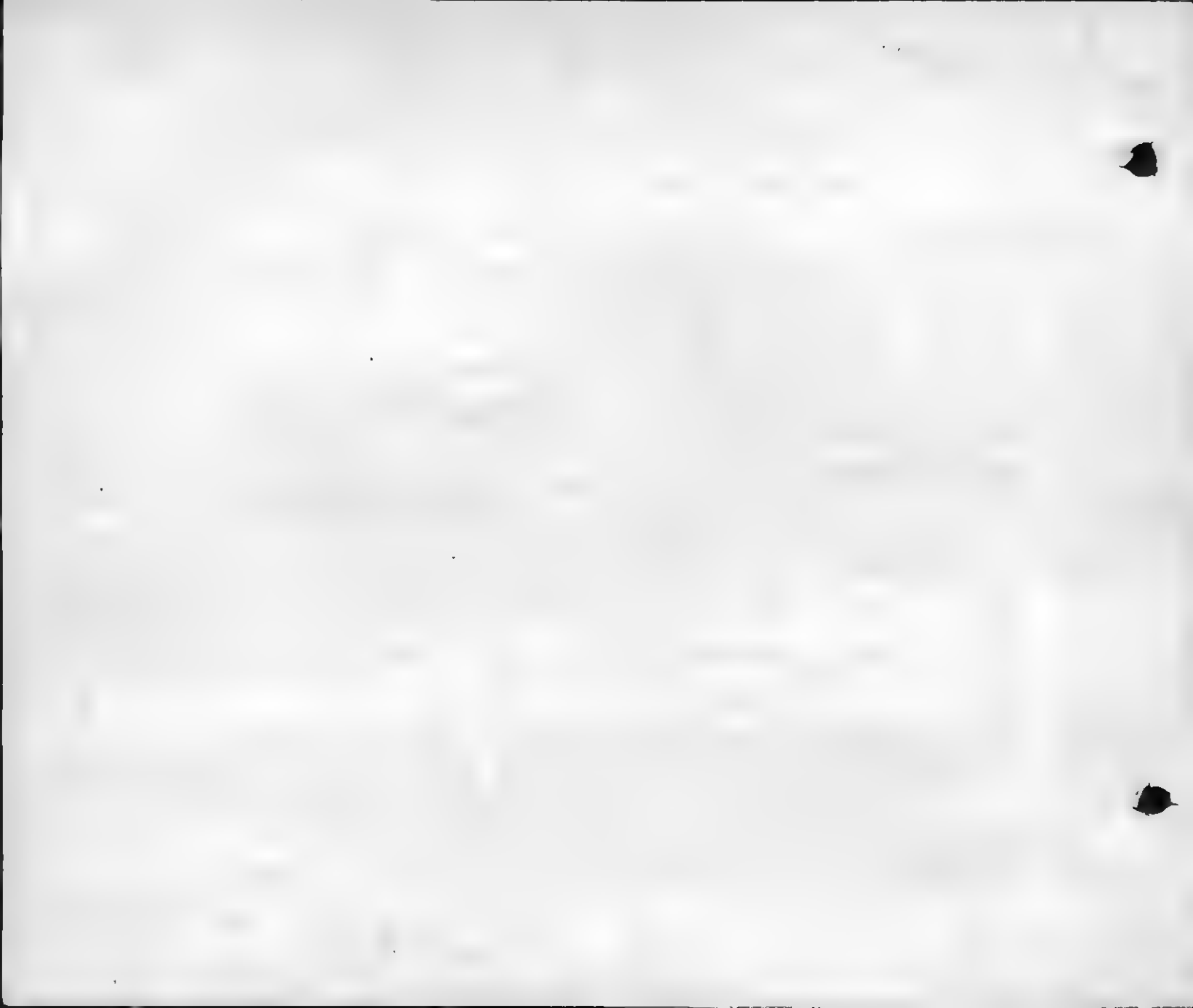
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>222 RIVERVIEW AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> d. STREET ADDRESS <u>222 RIVERVIEW AVE</u>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND FRANKLIN KERLEY</u>				4. DATE OF DEATH <u>APRIL 22 1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 29 1946</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>21</u> yrs.		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>ORVILLE H. KERLEY</u>				14. MOTHER'S MAIDEN NAME <u>BEULAH GAY KINGREA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS SHIRLEY KERLEY-255 RIVERVIEW</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INCINERATION - Residential Fire</u> 91 Conditions, if any, which gave rise to immediate cause (b) <u>91</u> (c) <u>91</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William C. Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William C. Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>APR 25 1962</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>				22d. LOCATION (City, town, or country) <u>COLGATE MD</u>			
23. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>				24a. REC'D BY REGISTRAR <u>PR 26 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>William C. Collins</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

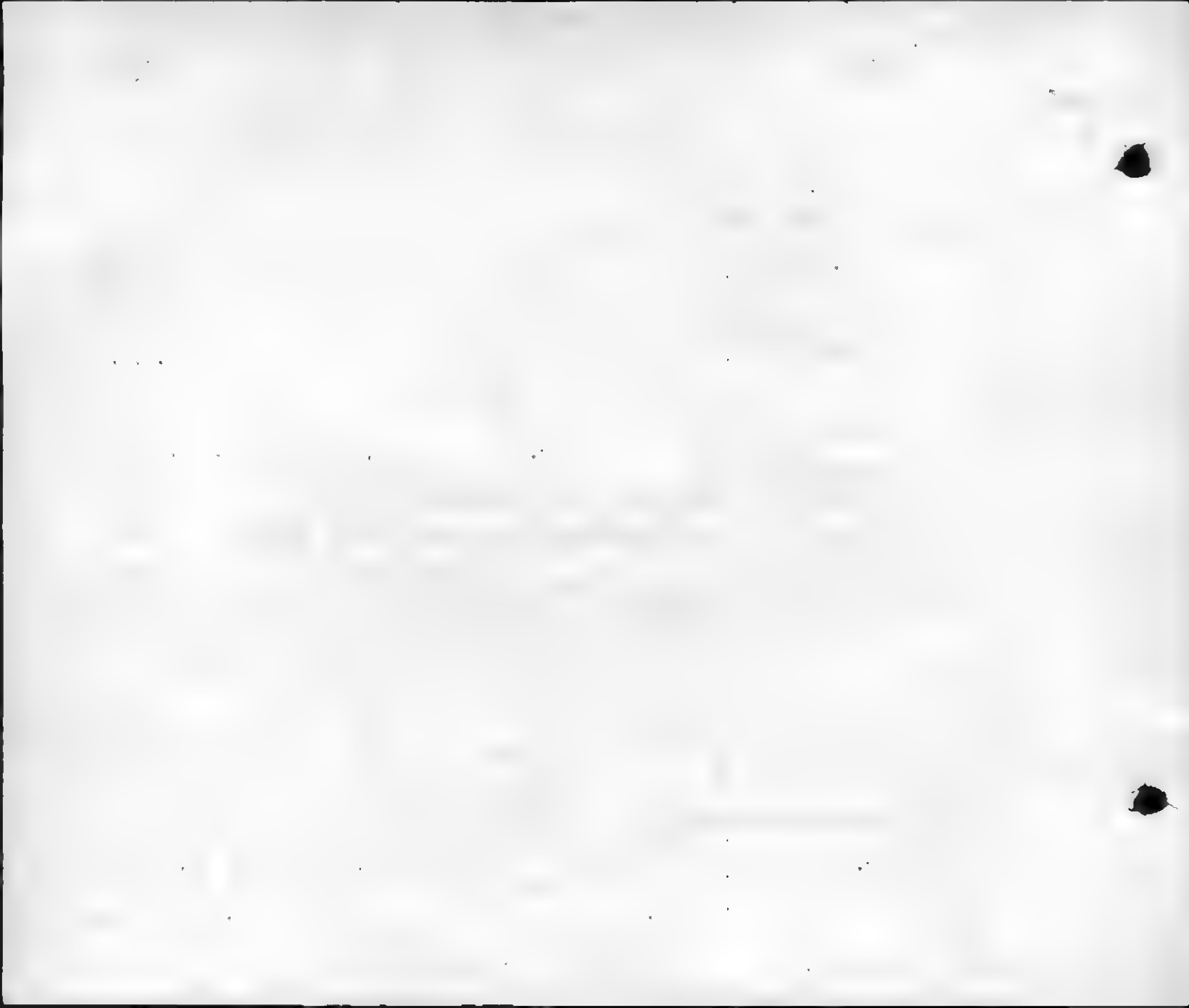
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04269

04266

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Catonsville</u> c. LENGTH OF STAY IN <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Rockdale</u> d. STREET ADDRESS <u>3524 Rolling Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mr. John T. Kirk</u>		4. DATE OF DEATH <u>April 3 19 62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1889</u>					
9. AGE (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.		
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Hebbville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Kirk</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-2299</u>					
17. INFORMANT <u>Mr. John A. Kirk, Baltimore 7, Md.</u>		Address <u>3524 Rolling Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho - pneumonia</u> DUE TO (b) <u>Metastatic Carcinoma of breast</u> DUE TO (c) <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>4 days</u> <u>One year</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>April 1st - 1962</u> to <u>April 3, 1962</u> that (I) (we) last saw the deceased alive on <u>April 3, 1962</u> and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wetherbee Fort</u>		22b. DATE SIGNED <u>4/5/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wetherbee Fort</u>		22d. ADDRESS <u>6 Dutton Ave., Baltimore 28, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-7-62</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Randallstown, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Young Byers</u>		25a. REC'D BY REGISTRAR <u>4/9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04271

04268

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ✓ c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) BALTIMORE CITY d. STREET ADDRESS 1901 ALICEANNE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALFRED		First Middle Last KOWALEWSKI		4. DATE OF DEATH Month Day Year APRIL 18 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 3/29/08 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDING MAINTENANCE		11. BIRTHPLACE (County & State, or foreign country) MISSISSIPPI			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH KOWALEWSKI		14. MOTHER'S MAIDEN NAME ROSIE ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-10-9090		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO 002.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC ALCOHOLISM				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/6 1962 to 4/18 1962 that (I) (we) last saw the deceased alive on 4/18 1962 and that death occurred 4/18 M, from the causes and on the date stated above.							
22a. SIGNATURE 		22b. DATE SIGNED 4/19/62		22c. PHYSICIAN'S NAME (Type) M. Newcomer, M.D., Superintendent			
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/23/62		23b. DATE THEREOF 4/23/62		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary			
23d. LOCATION (City, town or county) Baltimore		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE 		24a. ADDRESS 1930 Eastern Ave		25a. REC'D BY REGISTRAR APR 23 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. DATE					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

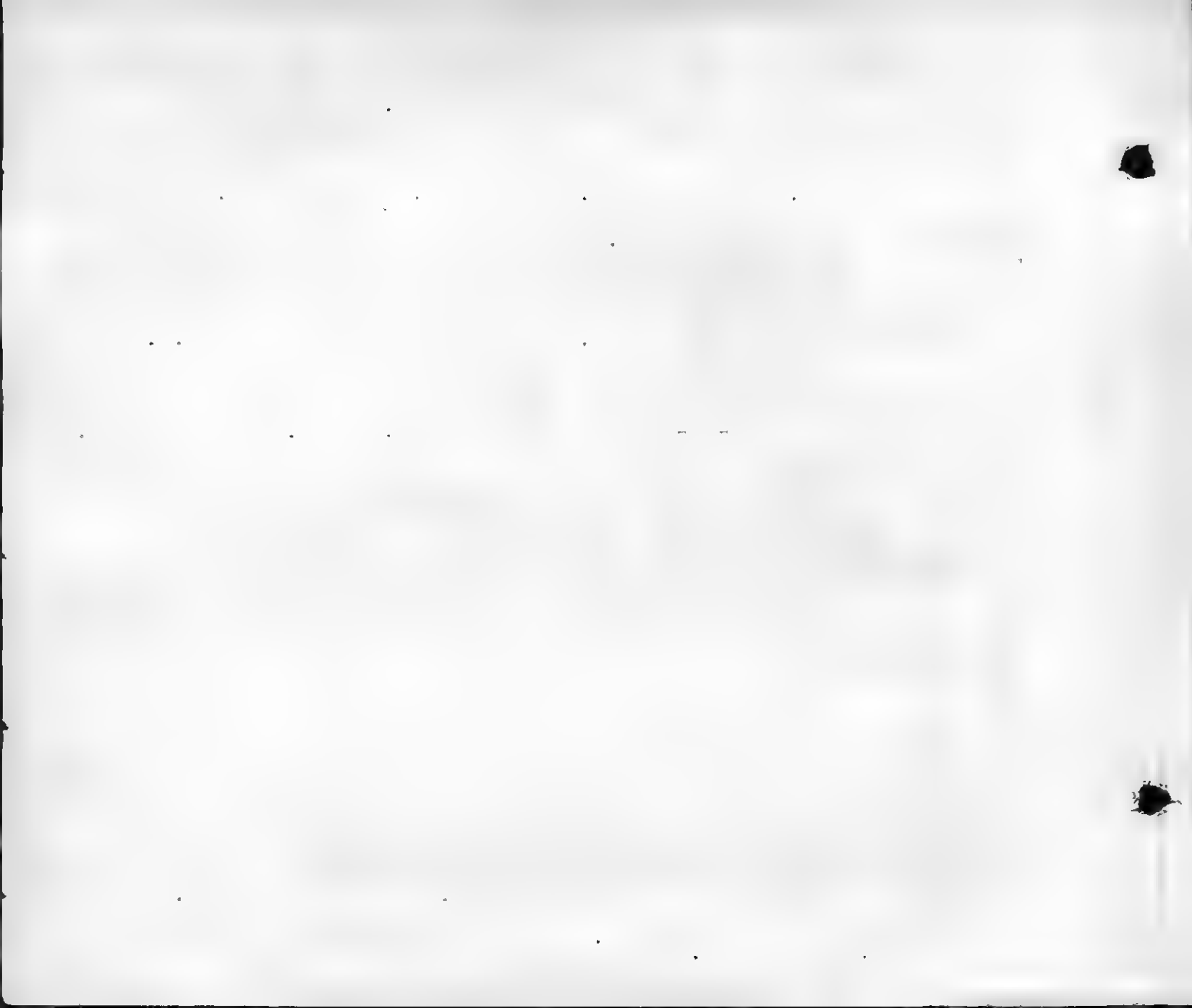
CERTIFICATE OF DEATH

Reg. Dist. No. 269

04272

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 N. Symington Ave. 28		d. STREET ADDRESS 830 N. Lakewood Ave.	
3. NAME OF DECEASED (Type or print) First ANNA Middle S. Last KRIZEK		4. DATE OF DEATH Month April Day 8 Year 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1884
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months 7 Days 1 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailoring		10b. KIND OF BUSINESS OR INDUSTRY Dvorak Bros.	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 217-09-9051		16. SOCIAL SECURITY NO. 217-09-9051	
17. INFORMANT Marie Wessel, 126 N. Symington Ave. 28		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V Disease - Coronary Arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/7 19 62 to 4/8 19 62 , that I last saw the deceased alive on 4/7 19 62 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1002 Ingham St. Baltimore, Md. DATE SIGNED 4/10/62			
ACTUAL SIGNATURE Kenneth Krizek, M.D.		DATE SIGNED 4/10/62	
PRINTED NAME (Type) Kenneth Krizek, M.D.		ADDRESS Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/62	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601 E. Madison St.		24a. REC'D BY REGISTRAR DATE APR 12 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

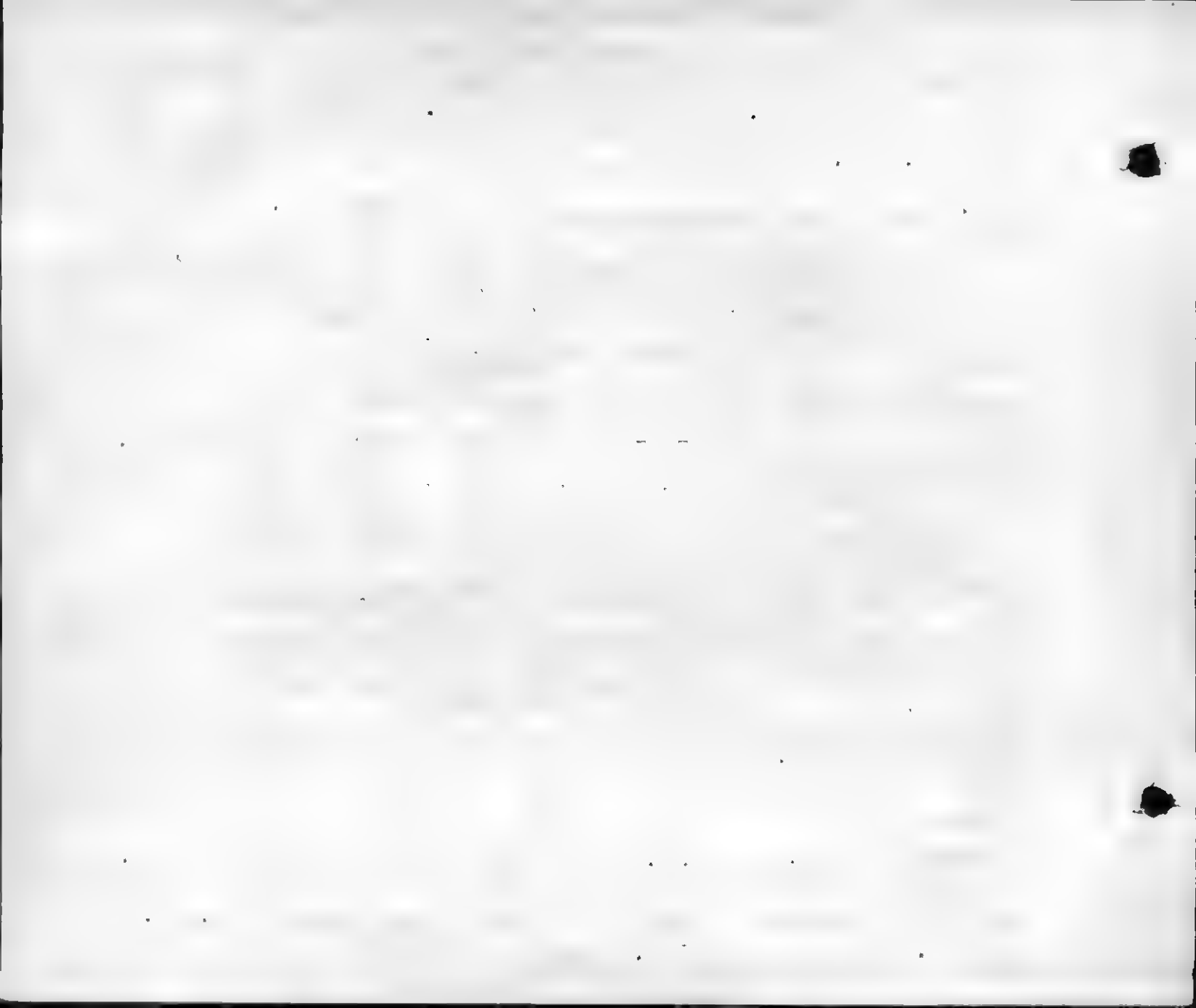
CERTIFICATE OF DEATH

Reg. 04273 No. 04270

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Baltimore</u> <input type="checkbox"/> Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Josephs Nursing Home</u>		d. STREET ADDRESS <u>1222 Tugwell Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>ZUZANNA KROLICKA</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packing House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-9660A</u>	
17. INFORMANT <u>Sophia Krolicka</u>		Address <u>2219 Orem Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>7 d.</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>62</u> to <u>11 April</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>11 April</u> , 19 <u>62</u> , and that death occurred at <u>7:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>April 13, 1962</u>			
ACTUAL SIGNATURE <u>James E. Rowe</u> M.D.		PHYSICIAN'S NAME (Type) <u>James E. Rowe, M. D.</u> <u>1011 Frederick Road, Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Weber & Sons</u>		ADDRESS <u>401 S. Chester St</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 13 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Christy S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1. TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1. TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04274

04271

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5311 La Mar Ave</u>		d. STREET ADDRESS <u>5311 La Mar Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Annie May LaMar</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1873</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>4</u> Hours <u>30</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William K. LaMar</u>		14. MOTHER'S MAIDEN NAME <u>Annie B. Cromwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Walter LaMar</u>		Address <u>5623 Gordenville Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO <u>Chronic Cardio Vascular Disease</u> DUE TO <u>Senility</u> CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>April 3, 1962</u> that (I) (we) last saw the deceased alive on <u>April 2, 1962</u> and that death occurred at <u>12M</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B B Brumbaugh M.D.</u>		22b. DATE SIGNED <u>4/4/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		22d. ADDRESS <u>5609 Main St. Edgemoor, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Olives Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick, Frederick Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase Inc. 1328 Sulfur Spring Rd.</u>		25. REC'D BY REGISTRAR DATE <u>APR 6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04272

1. PLACE OF DEATH a. COUNTY Catonsville MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY 1114411	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Catonsville Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose or Rosalie Larson		4. DATE OF DEATH Month April Day 28 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7 1892
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR: Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chamber Maid		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hubbe		14. MOTHER'S MAIDEN NAME Margaret Gettman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 219-28-6366	
17. INFORMANT Mrs Lillian Czaykowski		Address 33 S. Decker Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cardio Vascular DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/12/62 to 4/12/62 , that I last saw the deceased alive on 4/12/62 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Avenue DATE SIGNED 4/30/62			
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.		Baltimore 29, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 1st 1962	Swarth	
23. FUNERAL DIRECTOR'S SIGNATURE Frank DeLoKoe		ADDRESS 322 S. High St	24a. REC'D BY REGISTRAR DATE MAY 2 '62
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

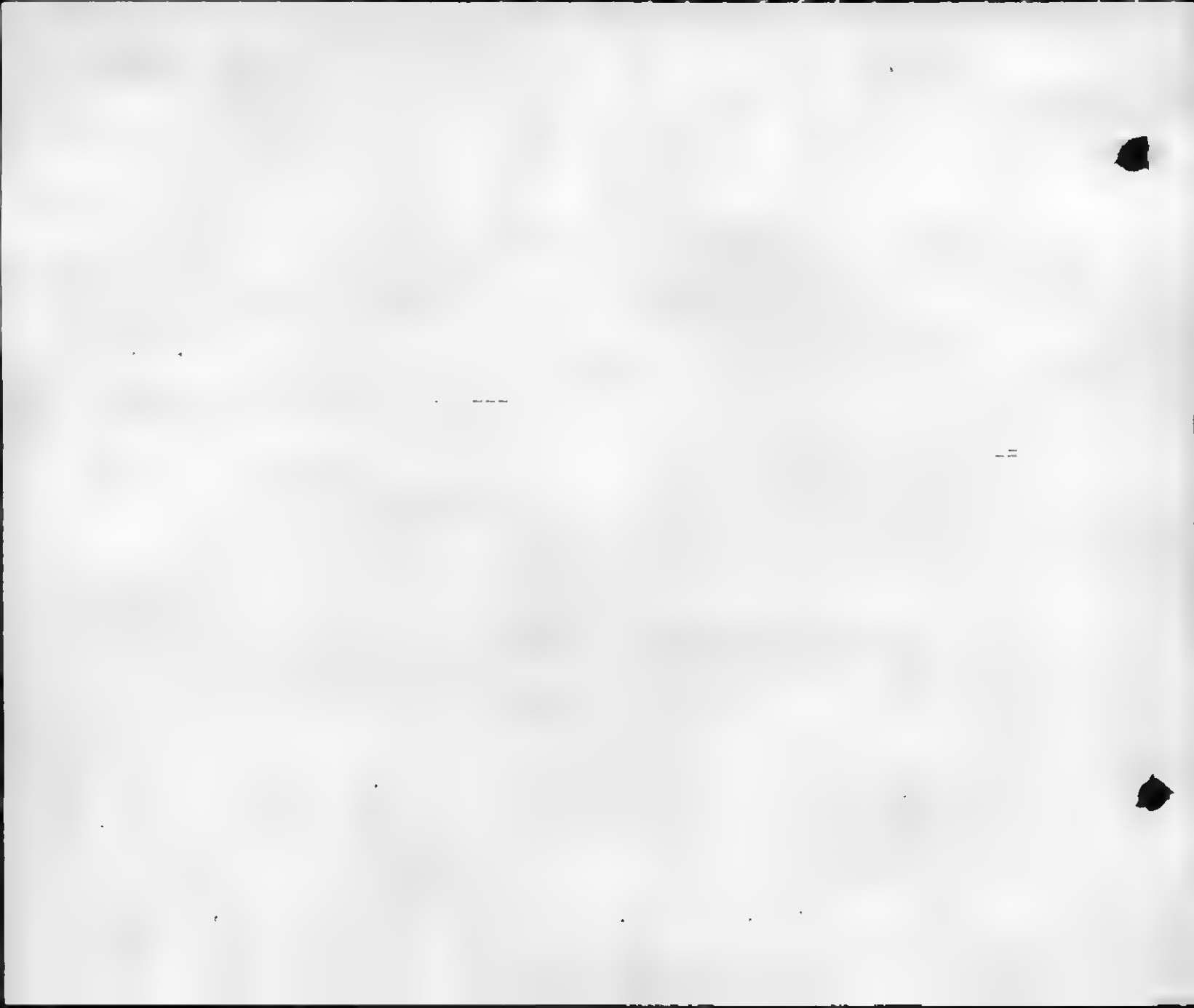
04276

CERTIFICATE OF DEATH

04273

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nest Beach, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>8mthldy</u>		STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>			
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Roland</u> Last <u>Lauer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1934</u>
9. AGE (in years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Roland Lauer</u>		14. MOTHER'S MAIDEN NAME <u>unknown Mary Stallings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. RECORDS: <u>SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>5-1-8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) DUE TO (c)		<u>Fatty Liver due to undetermined cause</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Urinary cystitis; acute left pyelitis</u>			
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (this hospital) attended the deceased from <u>April 7, 1962</u> to <u>April 8, 1962</u> , that (we) last saw the deceased alive on <u>April 8, 1962</u> and that death occurred at <u>7:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga, M.D.</u>		22b. DATE SIGNED <u>April 8, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 10, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Harmony Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>near Owings, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>APR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hinkle</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR FUNERAL DIRECTOR: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04277
04277
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b. <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1973 Snyder Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HAROLD W LETTS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1899</u>	
9. AGE (in years, lay birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Charleston, S. C</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. Letts</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>220-30-3797</u>	
17. INFORMANT <u>Clinical Records, VAH Ft Howard, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA RIGHT LUNG WITH METASTASES TO RIGHT KIDNEY AND TAIL OF PANCREAS</u> Conditions, if any, which gave rise to immediate cause (b) <u>UNK</u> (c) <u>DUO TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>8:40</u> p.m. <u>PM</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH FT HOWARD, MARYLAND</u>	
20f. (City or town) <u>Balto.</u>		20g. (County) <u>Balto.</u>	
20h. (State) <u>Maryland</u>		21. I certify that (this hospital) attended the deceased from <u>April 5, 1962</u> to <u>April 19, 1962</u> , that (a) (we) last saw the deceased alive on <u>April 19, 1962</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE SIGNED <u>4/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAH FT HOWARD, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-23-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>		23d. LOCATION (City, town or county) <u>Balto. Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Blight Inc.</u>		25a. DATE BY REGISTRAR <u>APR 24 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		25c. ADDRESS <u>6009 Harford Rd. Balto. 14</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

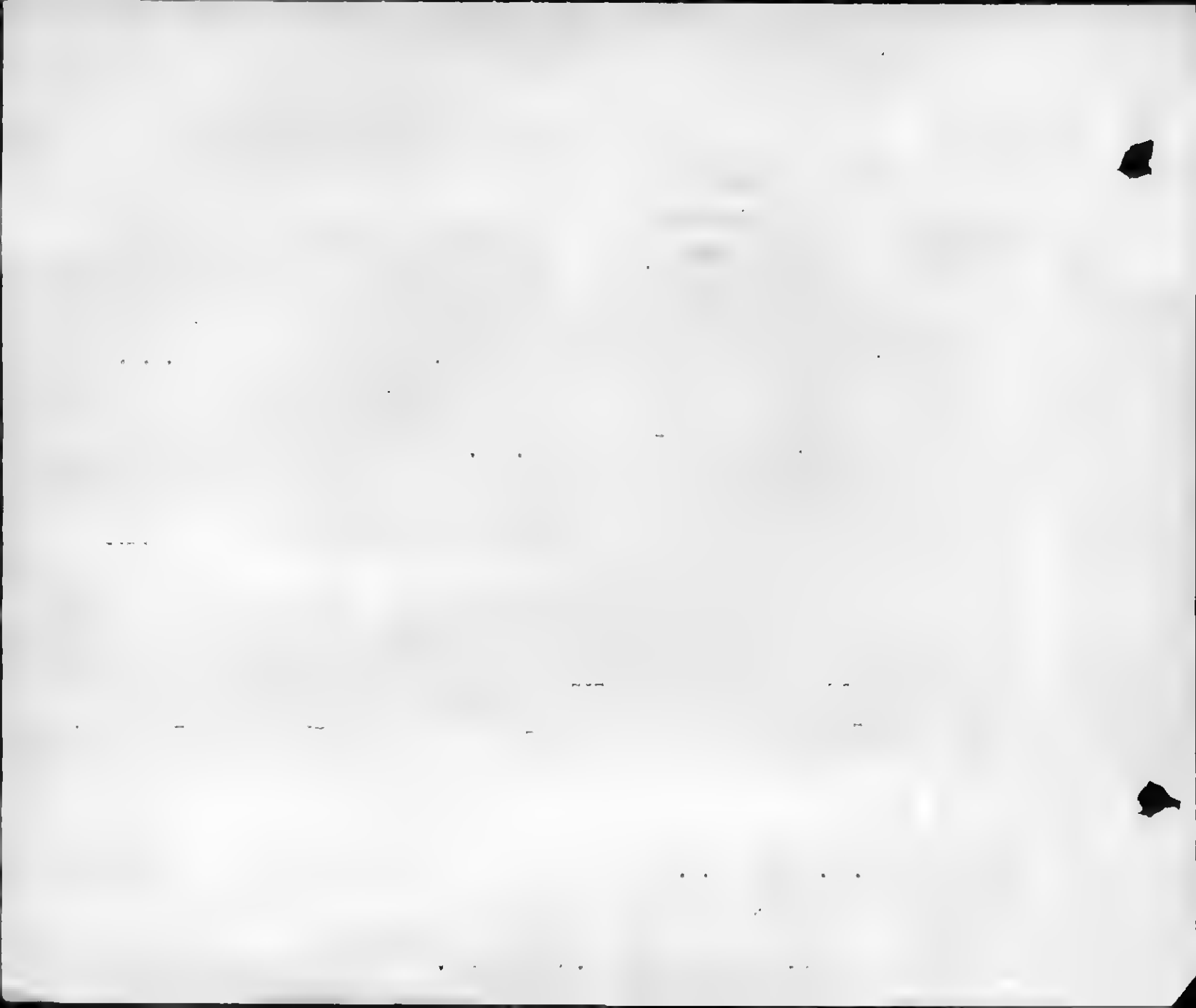
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SM 9'60

04278

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04275

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>1009 Sumpter Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN H. LITTLE</u>		4. DATE OF DEATH Month Day Year <u>APRIL 9 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/05</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Little</u>		14. MOTHER'S MAIDEN NAME <u>Annie Kessler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 12/27/27; 5/14/28</u>		16. SOCIAL SECURITY NO. <u>216-07-2897</u>	
17. INFORMANT <u>Clin. Rec. VAH, Fort Howard, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>MASSIVE PULMONARY INFARCT</u> (c) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>---</u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month Day Year Hour a.m. <u>---</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>		22d. LOCATION (City, town, or country) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Cvach Funeral Home, 1211 Chesaco Ave. Rosedale, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 17 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Truitt</u>		DATE <u>4/9/62</u>	



TO HOSPITAL OR A Dying Physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04279

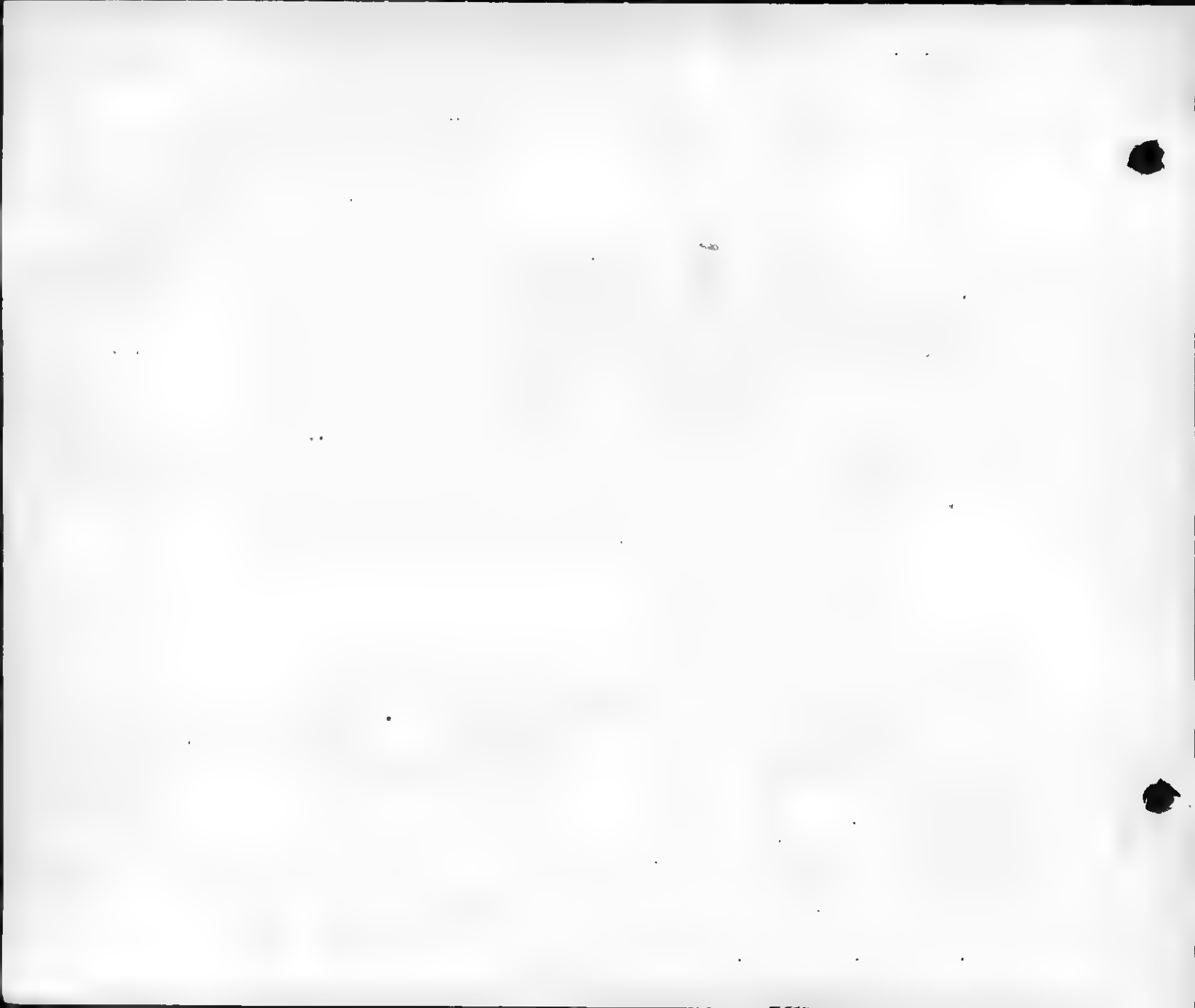
04276

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosedale Medical Center		1 d. STREET ADDRESS 523 South 46th STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle E. Last MADDOX		4. DATE OF DEATH Month APRIL Day 18 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1915
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER		10b. KIND OF BUSINESS OR INDUSTRY Hochschild, Kohn	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Guy Holditch	
14. MOTHER'S MAIDEN NAME Nellie Lutz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-03-1448		17. INFORMANT Robert L. Maddox, 523 S. 46th Street, Zone 24 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 423.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 18, 1962 to APRIL 18, 1962 that (I) (we) last saw the deceased alive on APRIL 18, 1962 and that death occurred at 4:15 P.M. from the causes and on the date stated above			
22a. SIGNATURE John G. Orth, M.D.		22b. ADDRESS 8019 PHILADELPHIA ROAD	
22c. PHYSICIAN'S NAME (Type) JOHN G. ORTH		22d. ADDRESS 8019 PHILADELPHIA ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-21-62	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City, town, or county) (State) Elkridge, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE W. S. Kline			

MEDICAL CERTIFICATION

I

M



CERTIFICATE OF DEATH

Reg. Dist. No.

04280

04277

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3:14			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hollen Hill Manor Nursing Home</u>				d. STREET ADDRESS <u>27 N. Potomac Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Sicavart</u> Middle <u>Martinson</u> Last <u>Martinson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 28, 1875</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Martin Martinson</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-8742</u>	17. INFORMANT <u>Lydia Johnson</u> Address <u>428 N. East Ave. Balto.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>paralysis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/10/62</u> 19 <u>62</u> , to <u>4/25/62</u> 19 <u>62</u> , that I last saw the deceased alive on <u>4/24/62</u> 19 <u>62</u> , and that death occurred at <u>12:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurel M. Serra</u> M.D.			ADDRESS (Street, city or town, state) <u>11 E. Church</u>			DATE SIGNED <u>4/27/62</u>	
PHYSICIAN'S NAME (Type) <u>Brewer & Mc</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3040 E. Baltimore St.</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 1 1962</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Moran</u>		

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

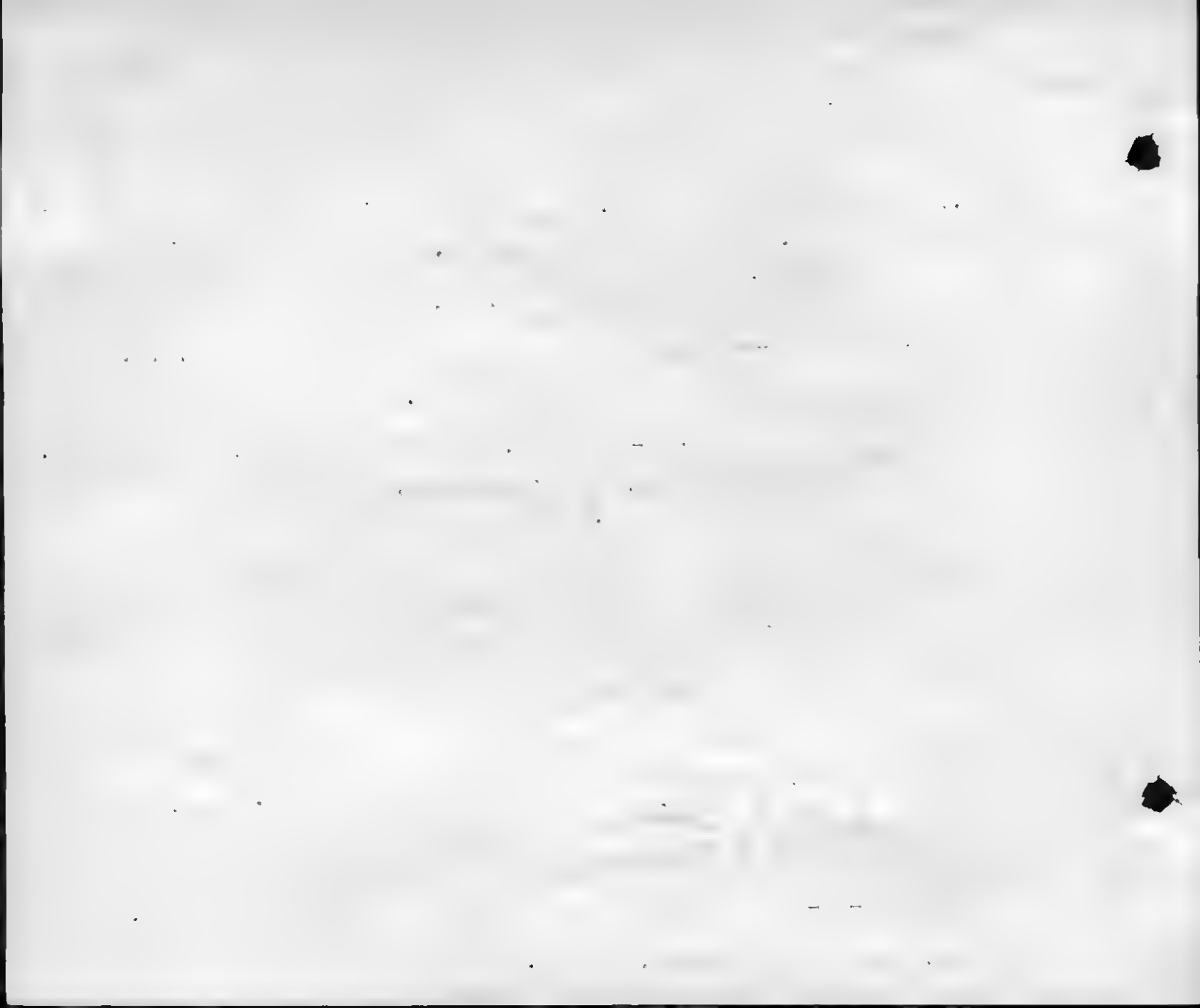
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

01231
04278
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> c. LENGTH OF STAY IN 1b <u>26 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Res. 2513 Sparrows Point Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> d. STREET ADDRESS <u>3014 Ritchie Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dewey</u> First <u>Sanson</u> Middle <u>Mason</u> Last	4. DATE OF DEATH Month <u>4</u> - Day <u>14</u> - Year <u>1962</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1898</u>	9. AGE (In years last birthday) <u>63</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed-- Barber</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Mason</u>	14. MOTHER'S MAIDEN NAME <u>Lula V. Ward</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>216-07-1740</u>
17. INFORMANT <u>Mrs. Virginia Mason</u>	Address <u>3014 Ritchie Ave.</u>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>425.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>425.1</u> (c) <u>425.1</u> DUE TO <u>425.1</u> cause last. (c) <u>425.1</u>	INTERVAL BETWEEN ONSET AND DEATH <u>30 sec</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>Diabetes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. ACTUAL SIGNATURE <u>Jack C Collins</u>	21. EXAMINER'S NAME (Type) <u>Jack C Collins</u>	21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <u>4-14-62</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>	22d. LOCATION (City, town, or country) (State) <u>Pocomoke City Md.</u>
23. FUNERAL DIRECTOR <u>JOHN J. DUDA</u>	Address <u>7922 Wise Ave. 22, Md.</u>	24a. REC'D BY REG. STRAR <u>APR 17 1962</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH


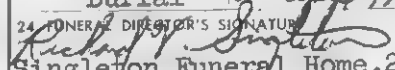

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

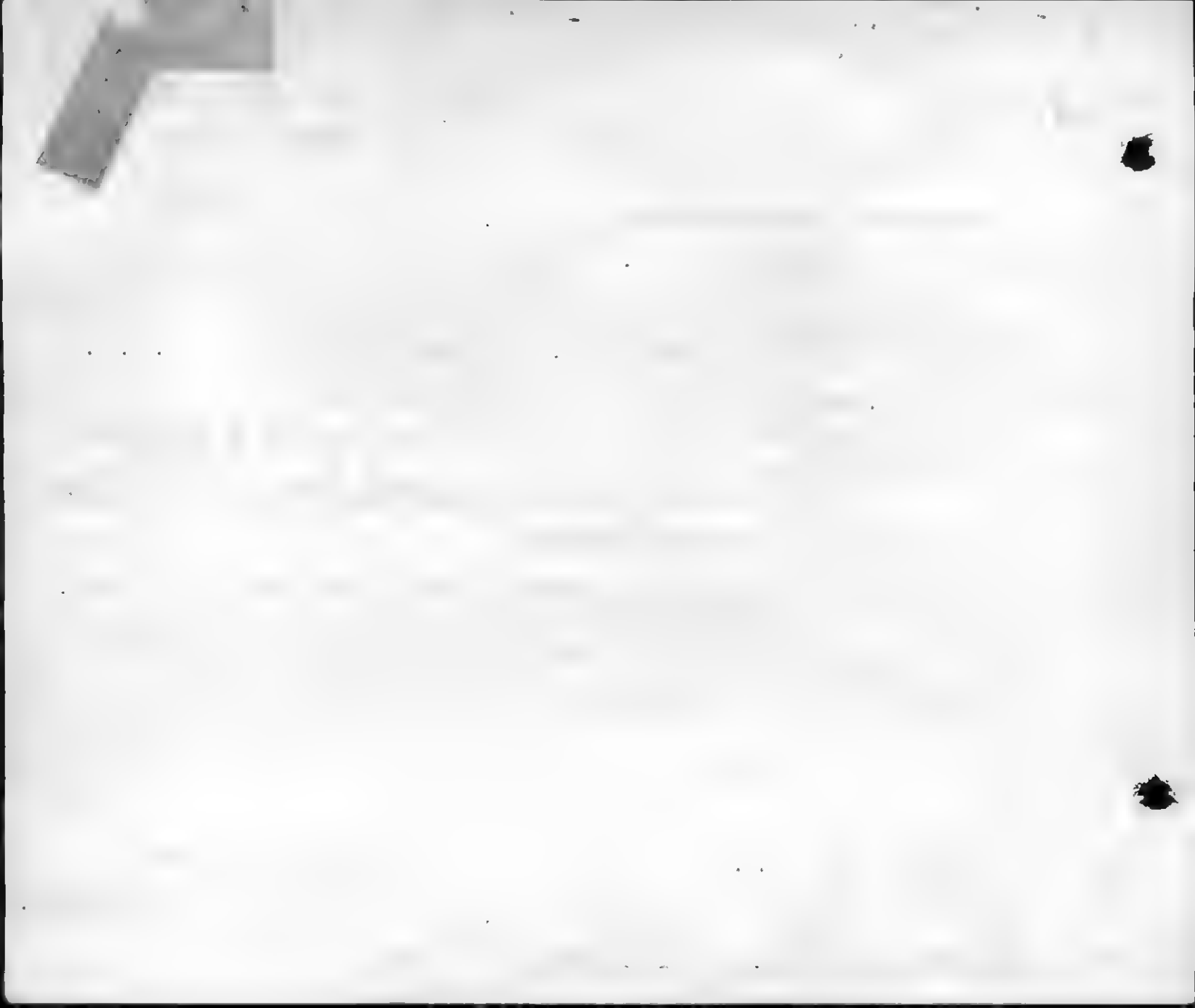
04282

CERTIFICATE OF DEATH

04279

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 17 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Route 1 Box 359A Danza Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CLARENCE G. MAYR First Middle Last				4. DATE OF DEATH Month April Day 1 Year 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1915		9. AGE (In years last birthday) 46 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer				10b. KIND OF BUSINESS OR INDUSTRY Transfer Co.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence G. Mayr				14. MOTHER'S MAIDEN NAME Gertrude Grief				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II 16. SOCIAL SECURITY NO. 215-05-0421			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESIDUAL SQUAMOUS CELL CARCINOMA, RIGHT LUNG Conditions, if any, which gave rise to immediate cause (b) BILATERAL PNEUMONIA (a), stating the underlying cause last (c) METASTASIS TO STERNUM, RIBS AND RIGHT KIDNEY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 5 DAYS UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15, 1962 to April 1, 1962 , that (1) (we) last saw the deceased alive on April 1, 1962 , and that death occurred at 7:05 P.M., from the causes and on the date stated above.											
22a. SIGNATURE 				22b. DATE SIGNED 4/2/62				22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-2-62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Ritchie Highway, Glen Burnie, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE 				25a. REC'D BY REGISTRAR Glen Burnie, Maryland				25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

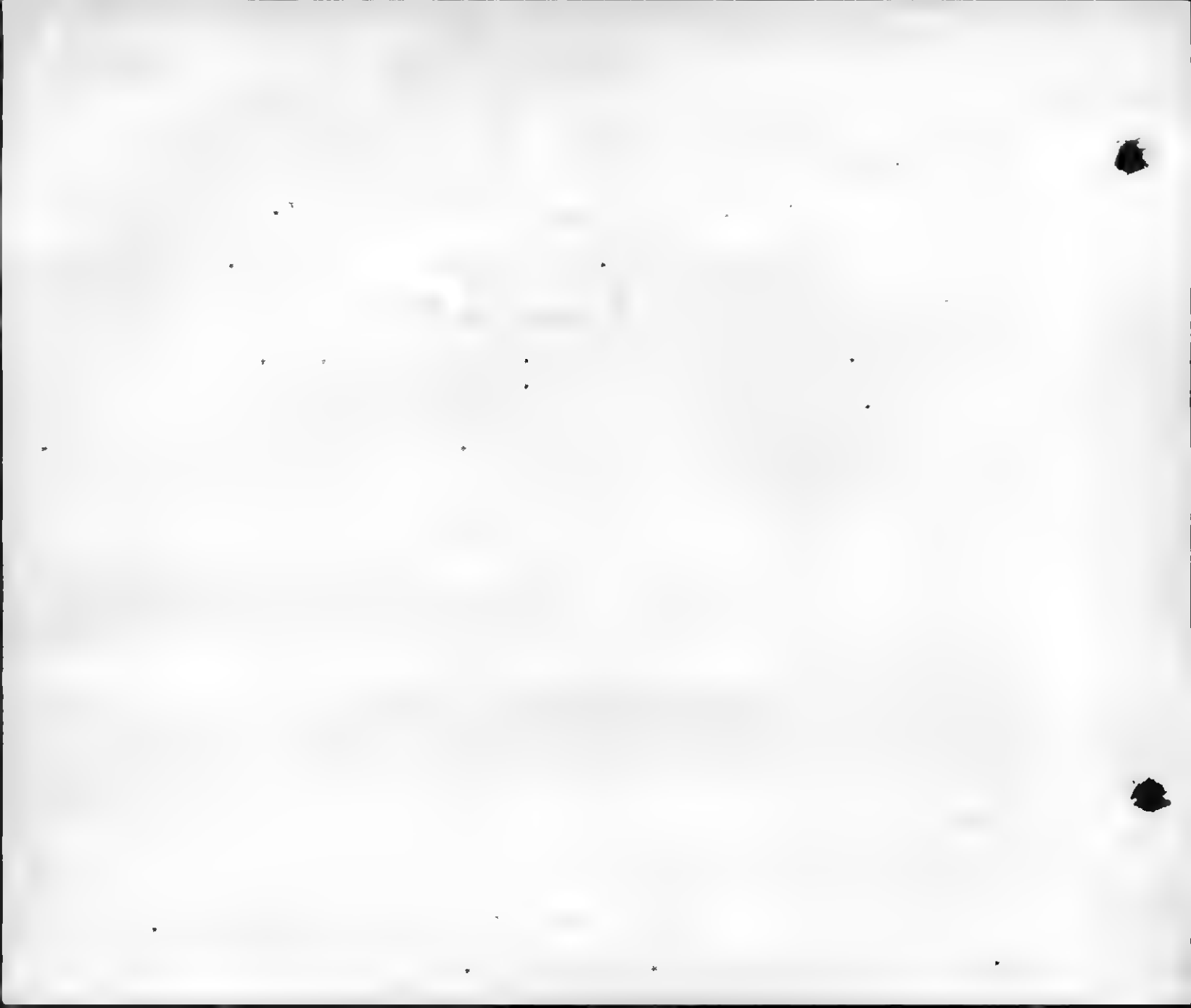
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04283

CERTIFICATE OF DEATH

Reg. Dist. No. 04280

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 1 WEEK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES, FUSTING AVE		d. STREET ADDRESS 4225 WICKFORD RD.	
3. NAME OF DECEASED (Type or print) ELIZABETH M. Mc GOVERN		4. DATE OF DEATH APR. 2 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ABOUT 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PUB. HEALTH NURSE, BALTO.		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD.	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES P. MCGOVERN		14. MOTHER'S MAIDEN NAME CLARA SHAUGHNESSY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT CLARA M. MCGOVERN		Address 4225 WICKFORD RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIECTASIS - ARTERIOCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1950 to Apr 2, 1962 , that I last saw the deceased alive on Sept 1, 1962 , and that death occurred at 8 A M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 6821 Reisterstown Rd, Balt DATE SIGNED 4-3-62			
ACTUAL SIGNATURE M W JACOBSON		M.D. 6821 Reisterstown Rd, Balt	
PHYSICIAN'S NAME (Type) M W JACOBSON MD		Back is inc	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/5/62	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W/ MEARS & SON		24a. REC'D BY REGISTRAR APR 6 '62	
ADDRESS 805 N. CALVERT ST.		24b. REGISTRAR'S SIGNATURE J. L. P. HARRIS	



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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04284 04281

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Owings Mills
c. LENGTH OF STAY IN TB
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chattolane & Valley Roads

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
e. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Owings Mills
d. STREET ADDRESS Chattolane & Valley Roads

3. NAME OF DECEASED (Type or print) Priscilla Stewart McHenry
4. DATE OF DEATH April 7 1962

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 6-11-1876
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years to birthday) 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY USA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Horton Stewart 14. MOTHER'S MAIDEN NAME Josephine Lurham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. James McHenry 17. INFORMANT Climdonl Maryland Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic Cardio
DUE TO (b) Vascular renal disease.
DUE TO (c) Parkinson's disease.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years
2 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 18, 1942 to April 7, 1962 that (I) (we) last saw the deceased alive on Apr 7, 1962 and that death occurred at 4:10 M, from the causes and on the date stated above.

22a. SIGNATURE Palmer F. C. Williams M.D. 22b. DATE SIGNED Apr 9, 1962
22c. PHYSICIAN'S NAME (Type) Palmer F. C. Williams 22d. ADDRESS Owings Mills, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-10-62 23c. NAME OF CEMETERY OR CREMATORY St. Thomas' 23d. LOCATION (City, town or county) (State) Garrison Forest Md.

24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd., Balto., Md. ADDRESS DATE APR 12 '62 25a. REC'D BY REGISTRAR Charles L. Housh 25b. REGISTRAR'S SIGNATURE



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

04283

04282

1. PLACE OF DEATH
a. COUNTY Baltimore County MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 214 Burke Avenue

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson

d. STREET ADDRESS 214 Burke Avenue

3. NAME OF DECEASED (Type or print) ANGELIA V. McMAHON

4. DATE OF DEATH April 16, 1962

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH MAY 27, 1893

9. AGE (In years last birthday) 68 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - RETIRED 10b. KIND OF BUSINESS OR INDUSTRY FED. RES. BANK 11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME John McMahon 14. MOTHER'S MAIDEN NAME Alice Schannessy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Family Records 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
929.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) alcoholism and arteriosclerotic cardiovascular disease
(a), stating the underlying cause last. DUE TO (c) Acute

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Found with head under water in bathtub

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE OF DEATH PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found with head under water in bathtub

20c. TIME OF INJURY Month, Day, Year 3:00 P.m. April 16, 1962 20d. INJURY OCCURRED While ☐ Not While ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Towson (County) Baltimore (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐

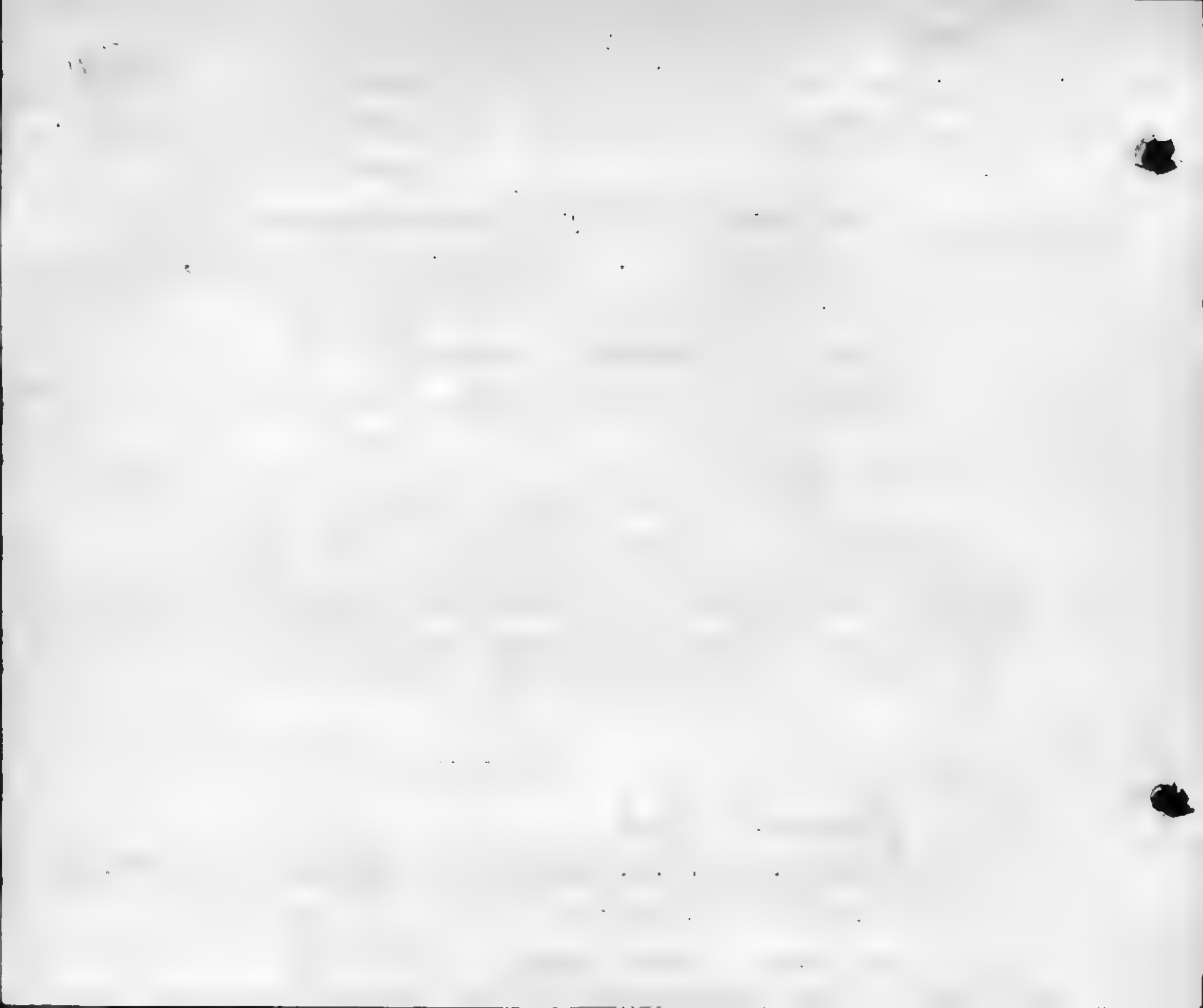
ACTUAL SIGNATURE Howard G. Shaub M.D. DATE SIGNED April 17, 1962

EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. Address (Street, city, town, or country) Baltimore, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF Apr. 18, 1962 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. 22d. LOCATION (City, town, or country) Baltimore, Md.

23. FUNERAL DIRECTOR John Burke's Sons, Towson, Md. ADDRESS

24a. REC'D BY REGISTRAR APR 19 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Kane



TO HOSPITAL, TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

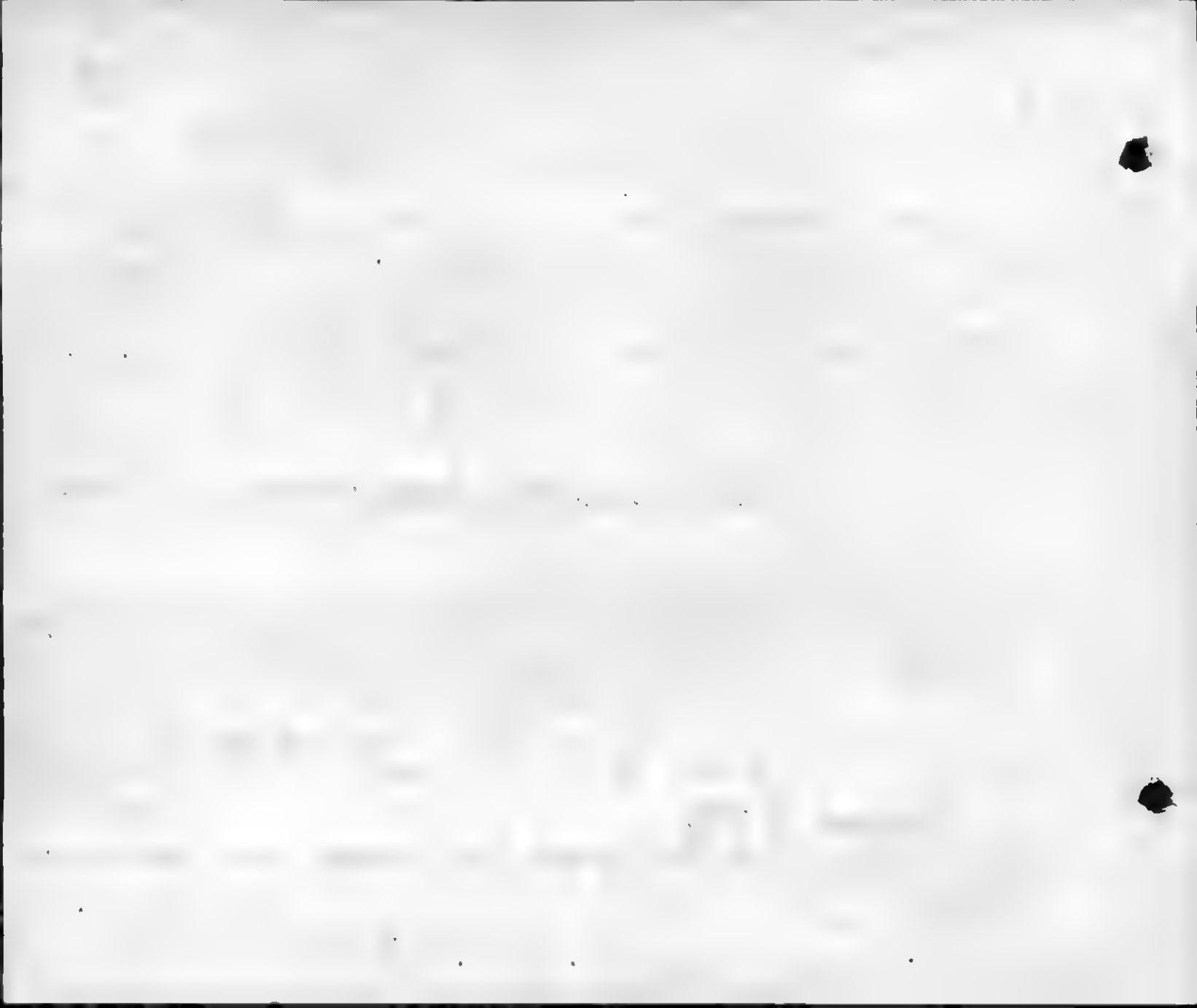
VR A15 (4)
15M 9/60

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04286

04283

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b <u>one month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>301 Northway</u>	
3. NAME OF DECEASED (Type or print) <u>David Lyon McPherson Sr.</u> First Last Middle 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 29, 1864</u> 9. AGE (In years last birthday) <u>97</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McPherson</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Lyon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>Miss Helen McPherson #301 Northway</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>20-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>20-0</u> DUE TO (c) <u>20-0</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>13 mo.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> 19 <u>48</u> to <u>4/14</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3/24</u> 19 <u>62</u> and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Reiter</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>		22b. DATE SIGNED <u>4/16/62</u> 22d. ADDRESS <u>606 Edmondson Ave. Balto-28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 17, 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore City, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u>		25. REGISTRAR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u>	



TO HOSPITAL or TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8 & 9 Film 3312 5/1/62 mh

04284

1. PLACE OF DEATH

a. COUNTY **Baltimore**

MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Lutherville, Md.

c. LENGTH OF STAY IN 1b

344-4mo

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

College Manor-Seminary Ave

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

e. STATE **Delaware**

f. COUNTY

c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Wilmington

d. STREET ADDRESS

108 Augustine Rd

g. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

Edwin

Byron Melson

4. DATE OF DEATH

April

22

1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☐ NEVER MARRIED ☐

8. DATE OF BIRTH

1880

9. AGE (In years)

79

1981

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bus. Exec

10b. KIND OF BUSINESS OR INDUSTRY

Accomac VA. Acco. Co

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

222-01-1142A DR. WM R. MILNOR 6616 N. CHARLES ST

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Septicemia, probable

INTERVAL BETWEEN ONSET OF DEATH

3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Urinary tract infection - Deacidatus ulcers chronic prostatitis

1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Generalized and cerebral arteriosclerosis, severe

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20c. TIME OF INJURY Hour e.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from... 1960 to... April 22, 1962, that (I) (we) last saw the deceased alive on... April 20, 1962, and that death occurred at 3:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Abraham Genecin

M.D.

ATTENDING PHYS.

☒

MED. DIRECTOR

☐ STAFF PHYS.

22b. DATE SIGNED

4/22/62

22c. PHYSICIAN'S NAME (Type)

ABRAHAM GENECIN MD

22d. ADDRESS

714 PARK AVE BALT-1 MD.

23a. BURIAL, CREMATION, 23b. DATE THEREOF

REMOVAL 4-24-62

23c. NAME OF CEMETERY OR CREMATORY

RIVERVIEW

23d. LOCATION (City, town or county)

WILMINGTON - DEL

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

TOWSON

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

WM COOK-TOWSON-1050 YORK RD

U-MD

DATE APR 24 '62

Arthur S. Kline



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

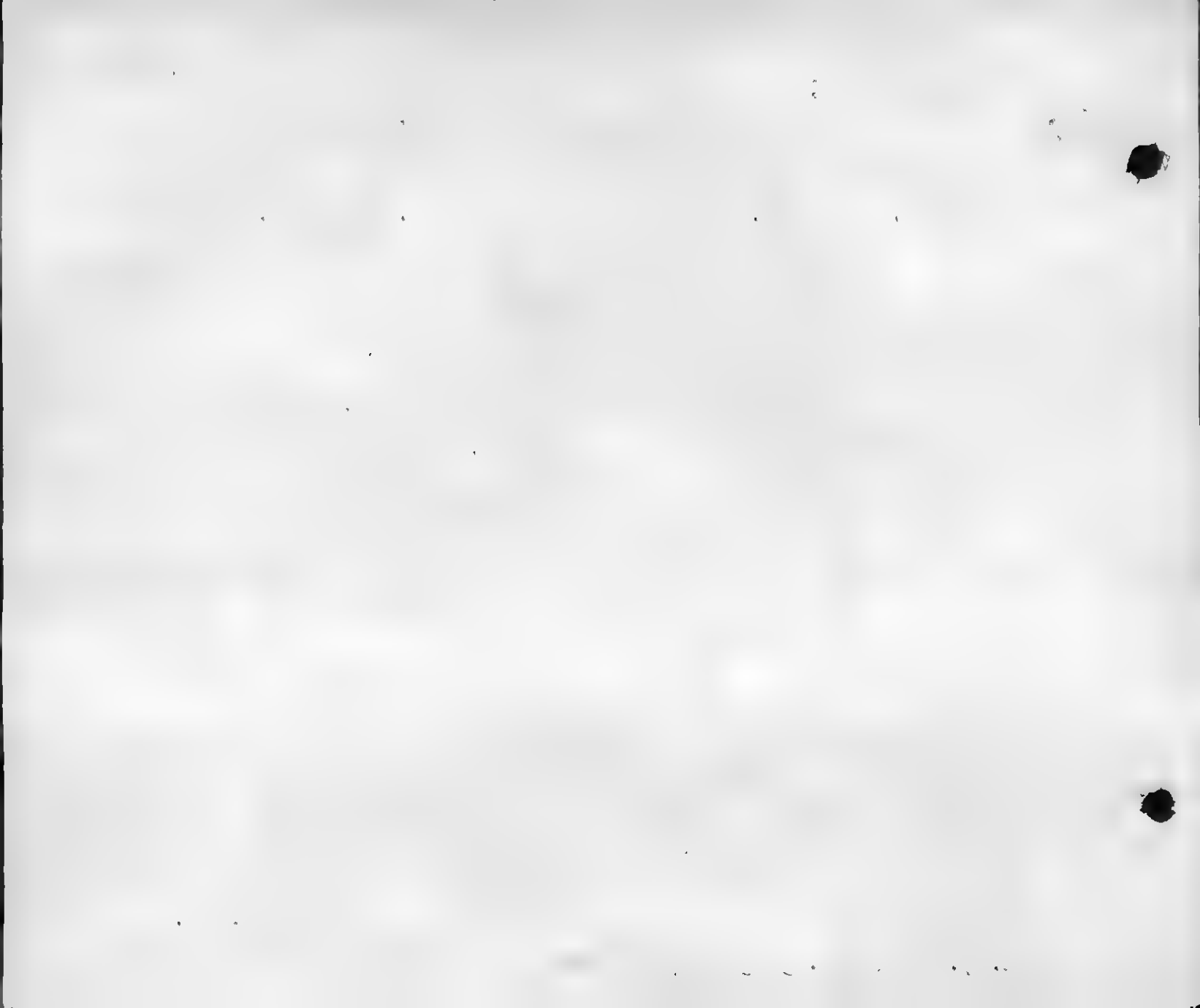
CERTIFICATE OF DEATH

04288

04285

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1901 E. Joppa Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>1901 E. Joppa Rd.</u>		3. NAME OF DECEASED (Type or print) <u>Helen Cassandra Miller</u> First Middle Last	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Henrietta M. Lopp</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>same</u>	
17. INFORMANT <u>John K. Miller</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4-4 DUE TO (b) <u>Valvular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Pulmonary infarct</u> DUE TO <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1952</u> to <u>April 27, 1962</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>April 27, 1962</u> , and that death occurred at <u>2:20</u> A.M. from the causes and on the date stated above.		22a. SIGNATURE <u>Lee K Fargo</u> M.D.	
22c. PHYSICIAN'S NAME (Type) <u>LEE K FARGO MD</u>		22d. ADDRESS <u>8155 LOCH RAVEN BLVD</u>		22b. DATE SIGNED	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-30-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		23e. (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc.</u> ADDRESS <u>5305 Hartford Road</u>	
25a. REC'D BY REGISTRAR <u>APR 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE	

VR A15 4
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

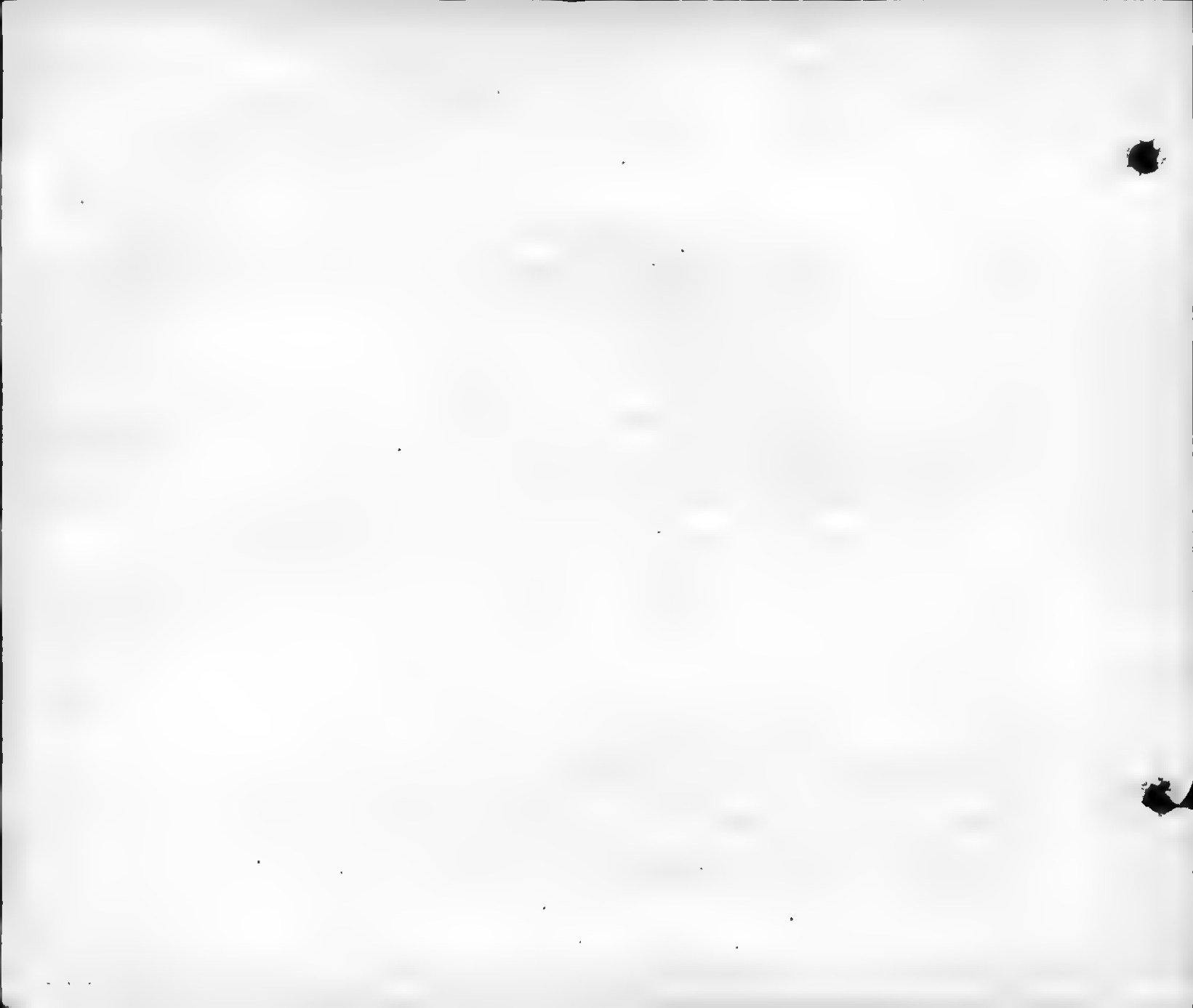
Reg. Dist. No. 04286

04289

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GLEN ARM.	
c. LENGTH OF STAY IN 1b 4 YEARS.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LONG GREEN PIKE	
3. NAME OF DECEASED (Type or print) First HELEN Middle CASSANDRA Last MONKS		4. DATE OF DEATH Month APRIL Day 30 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23, 1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME THOMAS JACKSON MONKS		14. MOTHER'S MAIDEN NAME ANNIE AMANDA MIDDENDORF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR JOHNE MONKS SR		Address LONG GREEN PIKE GLEN ARM, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X CORONARY ARTERY DISEASE. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE. (c) DIABETES MELLITUS.			INTERVAL BETWEEN ONSET AND DEATH 24 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 12, 1961 to DECEMBER 18, 1961 , that I last saw the deceased alive on DECEMBER 18, 1961 , and that death occurred at 8:04 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) JARRETTSVILLE PIKE DATE SIGNED 4-30-62 ACTUAL SIGNATURE Henry L. McCorkle M.D. JARRETTSVILLE PIKE PHYSICIAN'S NAME (Type) HENRY L. MCCORKLE MD Phoenix, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1962	
22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Methodist Cem.		22d. LOCATION (City, town, or county) (State) Rural Bel Air, Harford Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24a. REC'D BY REGISTRAR DATE MAY 2 '62	
24b. REGISTRAR'S SIGNATURE John L. Brown			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04290

CERTIFICATE OF DEATH

Reg. Dist. No. **04287**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 yr. 10 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home, Smithwood Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
f. STREET ADDRESS 3312 Hayward Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles W. Mooney		4. DATE OF DEATH Month Day Year April 26, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1874
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy, in Peoples' Court of Balto. City		10b. KIND OF BUSINESS OR INDUSTRY Solomon's Island, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Marion Virginia Garner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. George W. Mooney, 3312 Hayward Ave., Balto.	
17. INFORMANT Mr. George W. Mooney, 3312 Hayward Ave., Balto.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis DUE TO Generalized Arteriosclerosis (b) Peripheral Vascular Disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 60 4/26/62 to 19 4/27/62 that I last saw the deceased alive on 4/25/62 and that death occurred at 3:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Frederick Road DATE SIGNED 4/27/62			
ACTUAL SIGNATURE W. E. McGrath, M.D.		PHYSICIAN'S NAME (Type) W. E. McGrath, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/62	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Gannon		24a. REC'D BY REGISTRAR DATE APR 30 '62	
ADDRESS 4611 Park Heights, Balto.		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

1

T

TO HOSPITAL death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

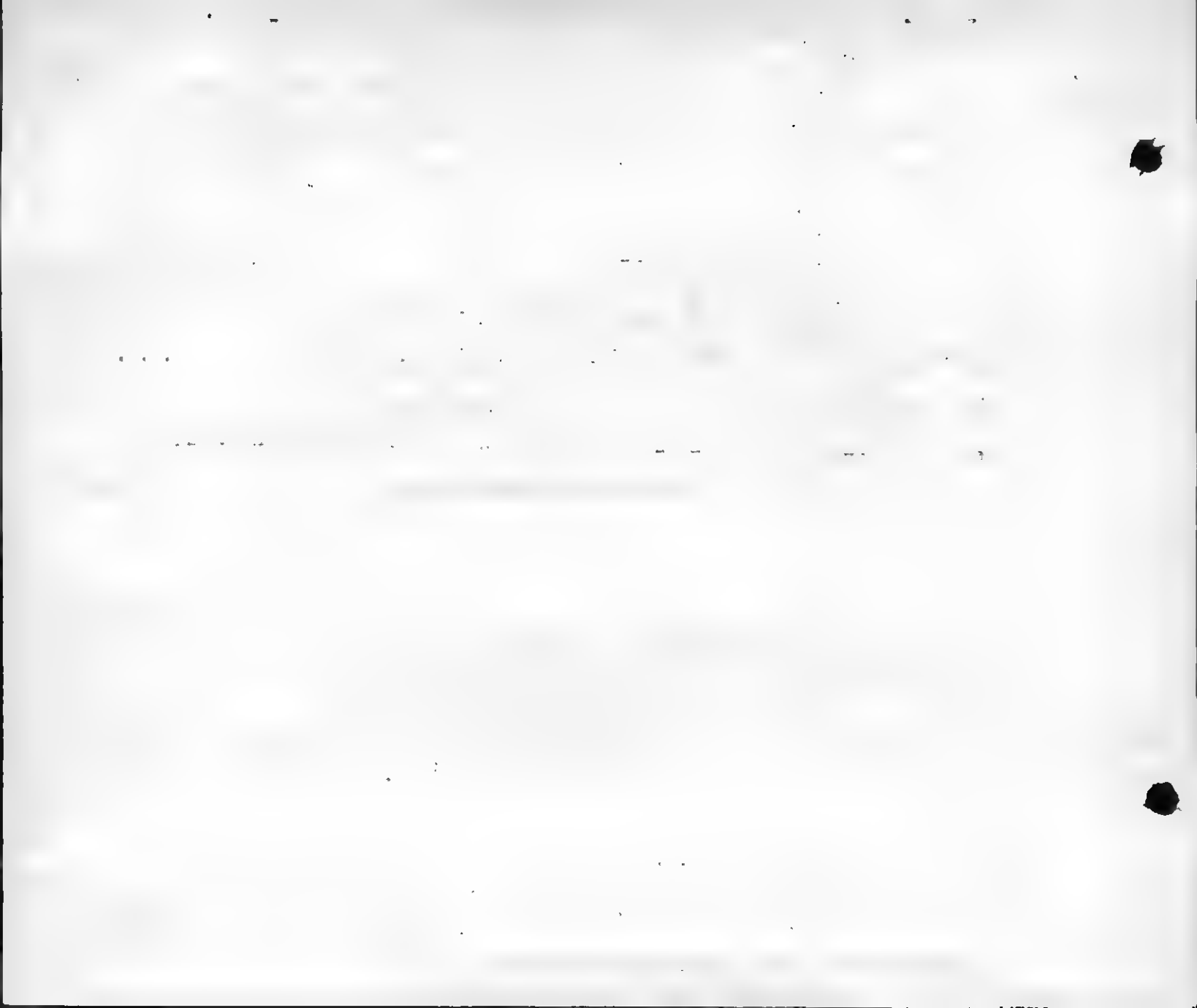
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04231

04238

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN TB <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>521 West 27th Street</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First Middle Last <u>MOONEY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>John Mooney</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Redmon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO. <u>217-05-8966</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.0</u> (c), stating the underlying cause last <u>420.0</u> DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia Left Lung; Laennec's Cirrhosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Clin Rec VAH Fort Howard Maryland</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 2, 1962</u> to <u>April 4, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 4, 1962</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Irving Freeman</u>		22b. DATE SIGNED <u>4/4/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D. Chief, Medical Service VAH Ft Howard, Md</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm-Cook Blight Inc</u>		25a. REC'D BY REGISTRAR <u>APR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Foss</u>		25c. ADDRESS <u>6009 Harford Rd Balto Md</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7, 61

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04292 CERTIFICATE OF DEATH 04289

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Randallstown c. LENGTH OF STAY IN IL MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3608 Blackstone Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Randallstown d. STREET ADDRESS 3608 Blackstone Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Marguerite J. Morgan First Middle Last		4. DATE OF DEATH April 15 19 62 Month Day Year	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 13, 1898 9. AGE (in years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Augusta, Georgia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Greene		14. MOTHER'S MAIDEN NAME Christine Roesel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Paul T. Morgan, Sr., Address 3608 Blackstone Rd. Randallstown, Md.		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 175.0 Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extreme cachexia (c) metastatic carcinoma secondary to Ovarian CA.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Dr. John J. Darrell attended the deceased from 3/12/62 , 19..., to 4/14/62 , 19..., that (I) did last saw the deceased alive on 4/14/62 , 19..., and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John J. Darrell 22c. PHYSICIAN'S NAME (Type) Dr. John J. Darrell		22b. DATE SIGNED 4/16/62 22d. ADDRESS 9017 Liberty Road, Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-62	
23c. NAME OF CEMETERY OR CREMATORY 8728 Liberty Road Randallstown, Md.		23d. LOCATION (City, town or county) (State) Augusta, Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE Long Byers		25a. REC'D BY REGISTRAR APB 19 '62 25b. REGISTRAR'S SIGNATURE William S. Hanna	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

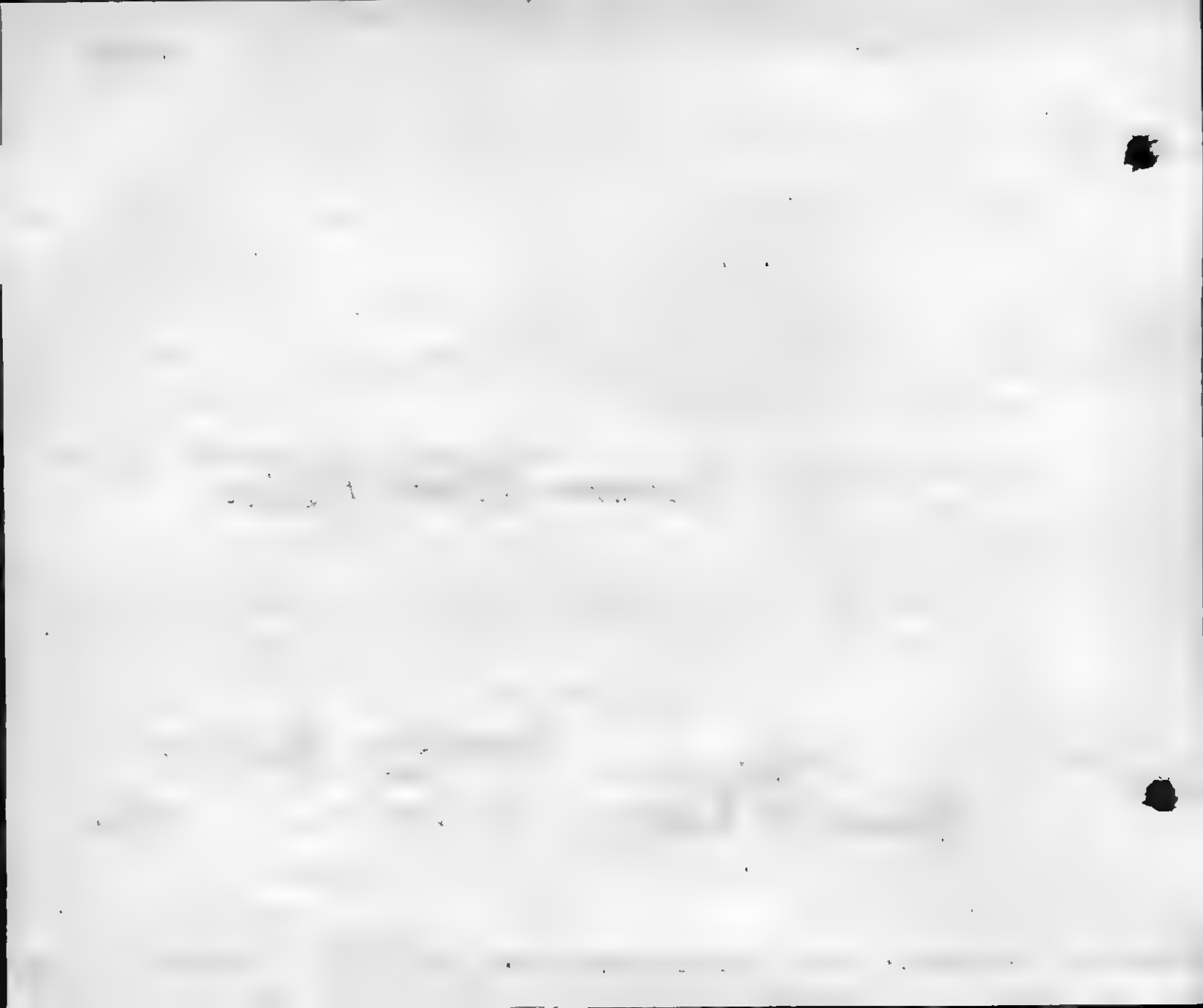
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04293

04290

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2305 Pott Spring Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>2305 POTT SPRINGS RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John V. H. Murray</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Aug 21, 1894</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA. R.R.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>ROBERT E. MURRAY</u> 14. MOTHER'S MAIDEN NAME <u>Mildred N. Murphy</u> Address <u>Heien</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mildred N. Murphy</u> Address <u>same</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>151X</u> IMMEDIATE CAUSE (a) <u>Carcinoma Stomach + Liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (his/her) attended the deceased from <u>March 15, 1962</u> to <u>April 8, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 8, 1962</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.				22a. SIGNATURE <u>Laurence C. Post</u> 22b. DATE SIGNED <u>4/8/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Laurence C. Post</u>				22d. ADDRESS <u>6805 York Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/10/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NAT'L</u>		23d. LOCATION (City, town or county) <u>BALTIMORE MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc</u> ADDRESS <u>5305 Harford Rd.</u>				25a. REC'D BY REGISTRAR <u>APR 10 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Haines</u>	



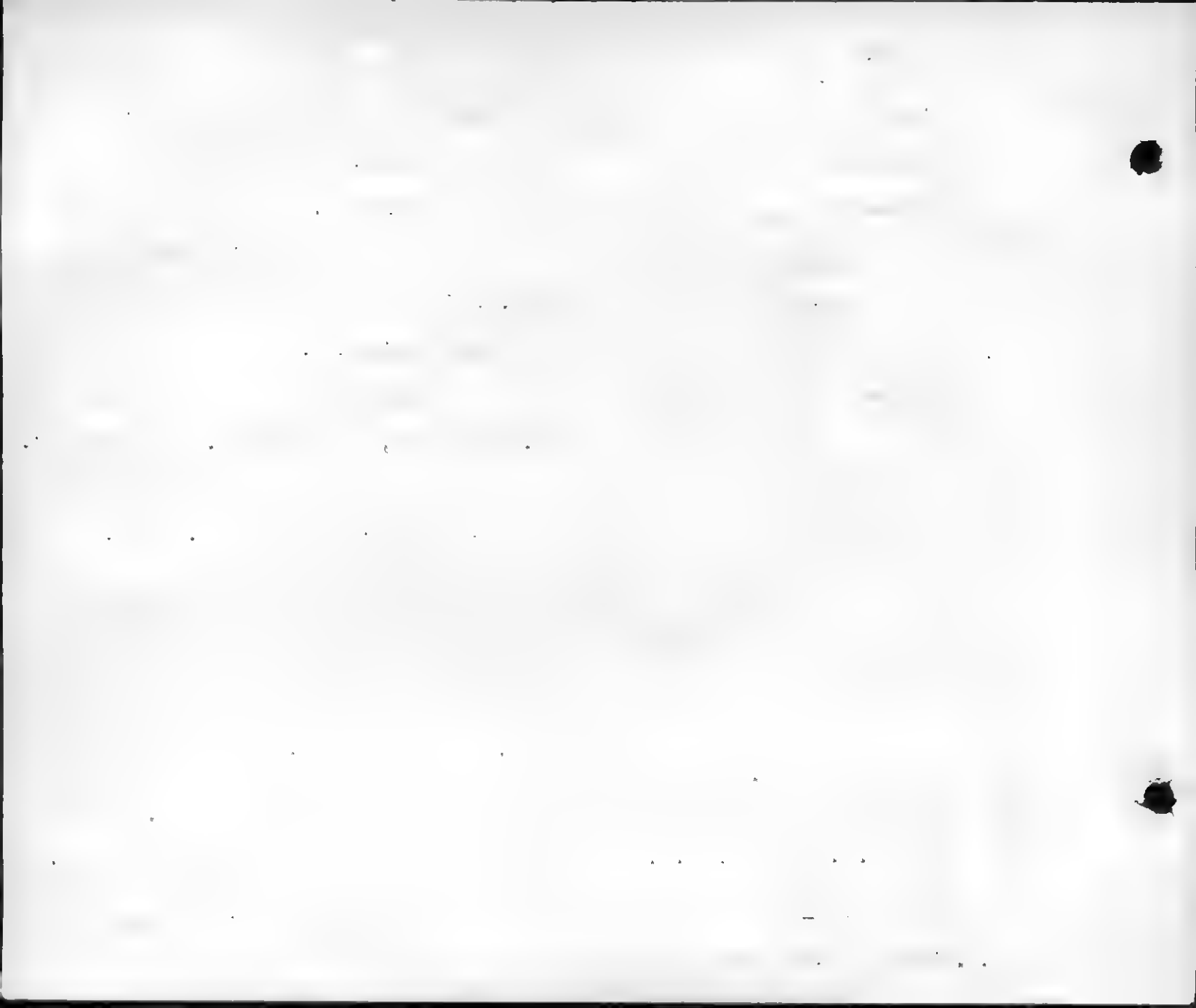
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Tillan please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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04294
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04291

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 Melrose Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JULIA Middle NARL Last		4. DATE OF DEATH Month April Day 9 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1879
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Charlottesville, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Julia Brown, 1308 French St. Wilmington, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage +42X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Renal Disease 6 yrs. 3 mo. 6 days DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 3rd 1956 to Apr. 9th 1962 , that (I) (we) last saw the deceased alive on Apr. 9th 1962 , and that death occurred at 11 M. , from the causes and on the date stated above.			
22a. SIGNATURE C. F. Maloney M.D.		22b. DATE SIGNED Apr. 10th 62	
22c. PHYSICIAN'S NAME (Type) C. F. Maloney, M.D.		22d. ADDRESS 57 Winters Lane - Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-12-1962	
23c. NAME OF CEMETERY OR CREMATORY Western Star		23d. LOCATION (City, town, or county) (State) Catonsville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE APR 12 '62	
25b. REGISTRAR'S SIGNATURE Robert S. Moore			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04295

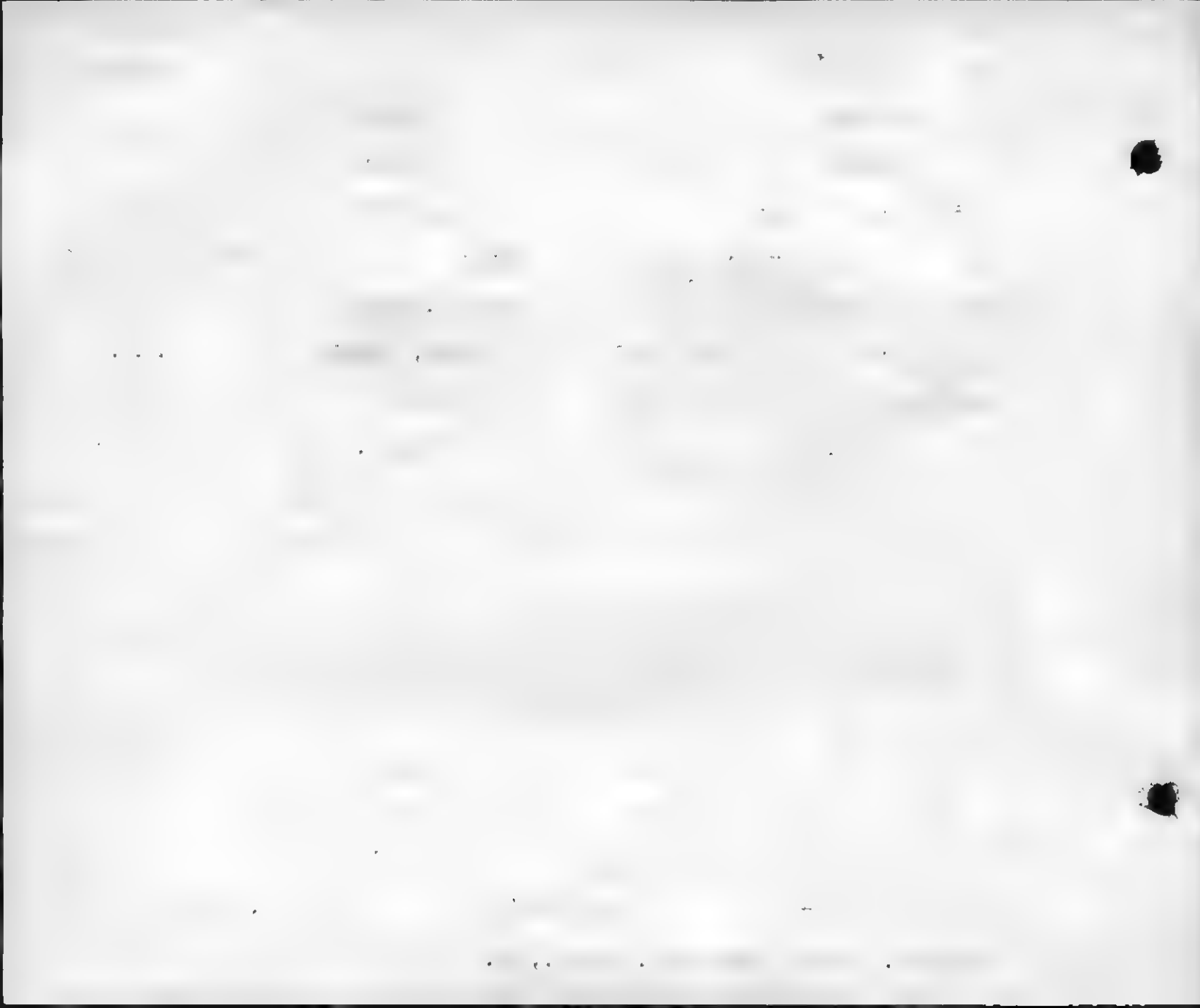
CERTIFICATE OF DEATH

04292

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemore c. LENGTH OF STAY IN 15 MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2526 Sycamore Avenue				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY B-14 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemore d. STREET ADDRESS 2526 Sycamore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Luther Owens		4. DATE OF DEATH Month April Day 13 Year 1962					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1900	9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		
10b. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (County & State, or foreign country) Augusta, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Owens		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service) Yes WW I		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Luther Owens, Jr. - 2526 Sycamore Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> (b) <u>Hypertensive Cardiovascular disease</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>8-23</u> 1962 to <u>April 13</u> 1962 , that (I) (we) last saw the deceased alive on <u>April 13</u> 1962 , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John V. Conway, M.D.</u>		22b. DATE SIGNED 4-13-62		22c. PHYSICIAN'S NAME (Type) John V. Conway, M.D.			
22d. ADDRESS 914 D STREET BALTO. 19, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-17-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE Charles R. Law 802 Madison Ave., Balto., Md. Arthur S. House					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1293

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		d. STREET ADDRESS 405 E. Hamburg St.	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle B. Last PEPERSACK		4. DATE OF DEATH Month April Day 4 Year 19 62	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1886
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George B. North		14. MOTHER'S MAIDEN NAME Marclena Ozmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO --	
17. INFORMANT Francis J. Pepersack		Address 7318 Yorktown Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2x0x MYOINFARCTION CARDIO-VASCULAR DISEASE - PULMONARY EDEMA DUE TO (b) DISEASE - MYOINFARCTION DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/1 , 19 61 , to 4/4 , 19 62 , that I last saw the deceased alive on 4/4 , 19 62 , and that death occurred at 3 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John F. Denny, Inc. M.D. John F. Denny, Inc. 4/6/62 PHYSICIAN'S NAME (Type) John F. Denny, Inc. BALTIMORE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/7/62	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. 715 Light St.		24a. REC'D BY REGISTRAR DATE APR 10 '62	24b. REGISTRAR'S SIGNATURE Christ S. Thomas



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.




MARYLAND STATE DEPARTMENT OF HEALTH

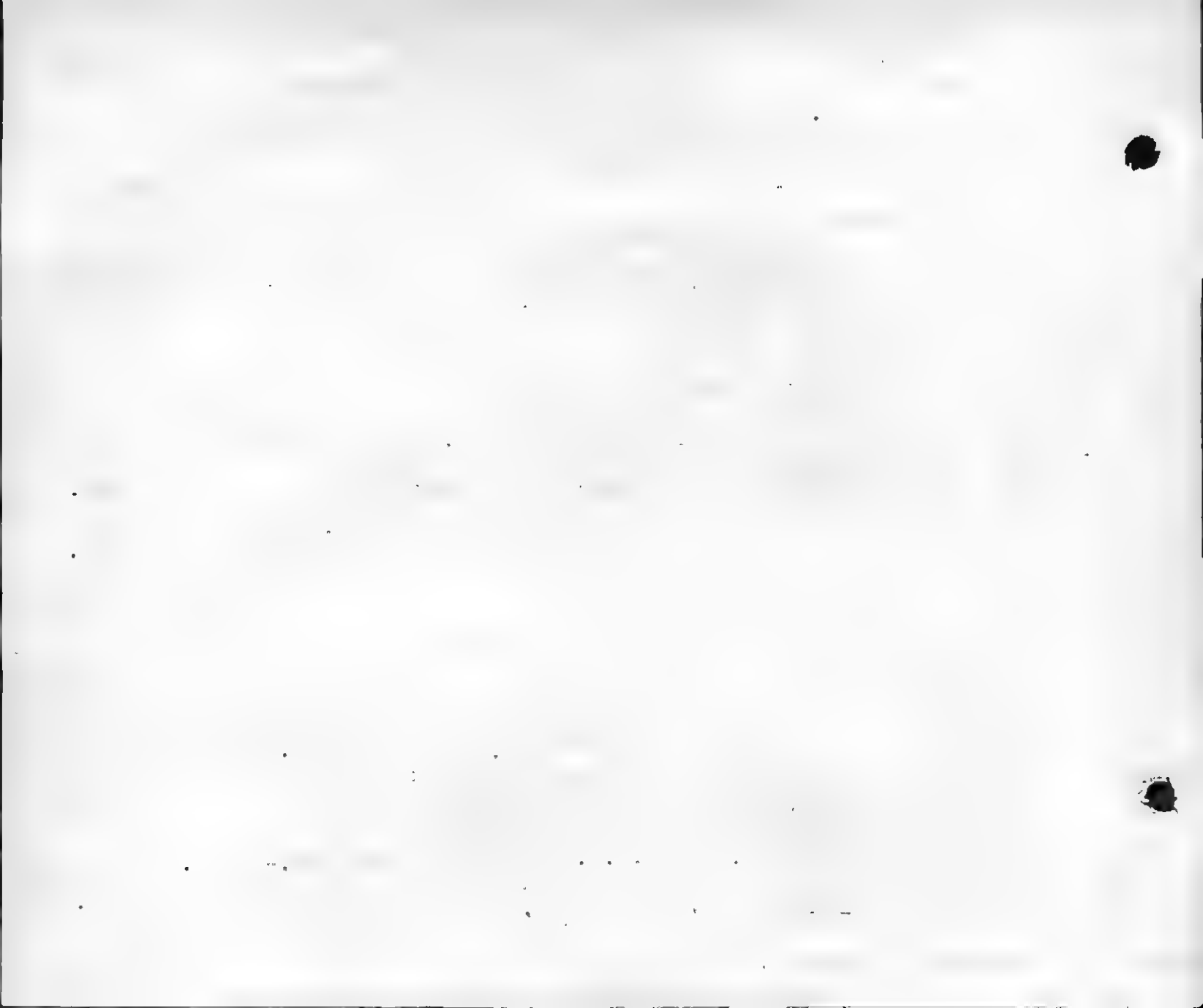
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04297

04294

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) White Marsh c. LENGTH OF STAY IN 1b 10 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 1072 Beach Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh d. STREET ADDRESS Box 1027 Beach Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Charles Pilkington		4. DATE OF DEATH 4 18 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-1877		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Smith				10b. KIND OF BUSINESS OR INDUSTRY Gorham Co				11. BIRTHPLACE (County & State, or foreign country) England				12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Samuel Pilkington				14. MOTHER'S MAIDEN NAME Emma King				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 037-05-0026				17. INFORMANT Mrs Olive L. Bragg Address Box 1027 Beach Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Myocardial Ischemia 293X DUE TO (b) Auto immune hemolytic disease, chronic progressive anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 wks. several yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic urinary retention due to prostatic enlargement																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Mar. 28, 1959 to Apr. 18, 1962 that (I) (we) last saw the deceased alive on April 7, 1962 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE 				M.D. Theodore E. Evans, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4/19/62							
22c. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.				22d. ADDRESS 9660 Belair Rd.-36-Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-21-1962				23c. NAME OF CEMETERY OR CREMATORY St John's Epic. Cemetery				23d. LOCATION (City, town or county) (State) Kingsville Md.							
24. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS LaSalle Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR APR 23 '62				25b. REGISTRAR'S SIGNATURE 							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04298 CERTIFICATE OF DEATH 04295

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN town <u>38yr8mth29dys</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1507 North Durham Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Adolph Henry Plitt</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>19 62</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1900</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> 490X } DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that to (this hospital) attended the deceased from <u>July 24</u> ¹⁹ ₂₃ to <u>April 26</u> ¹⁹ ₆₂ , that (I) was last saw the deceased alive on <u>April 26</u> ¹⁹ ₆₂ , and that death occurred at <u>3:00</u> P., from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-26-62	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 28, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		23d. LOCATION (City, town or county) <u>Baltimore Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Therman Schauf</u> ADDRESS <u>3512 FREDERICK AVE</u>				25a. REC'D BY REGISTRAR <u>APR 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04299

CERTIFICATE OF DEATH

04296

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Owings Mills

c. LENGTH OF STAY IN TB

3 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Rosewood State Training School

3. NAME OF DECEASED

(Type or print)

William

First Middle Last

H.

PLUMMER

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2/20/1888

4. DATE OF DEATH

Month

4

Day

24

Year

19 62

9. AGE (In years last birthday)

74 7/3 yrs.

10. UNDER 1 YEAR

Months Days

11. UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

dependent

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Henry G. Plummer

14. MOTHER'S MAIDEN NAME

Ella V. Murdock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

Rosewood Records, Owings Mills, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Uremia

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Carcinoma of bladder with invasion, muscular and left ureters

DUE TO

(c)

Nephro-sclerosis, senile

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

Mental retardation with behavioral reaction, idiopathic Hemiplegia, upper right

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (H) (this hospital) attended the deceased from... 11/10, 1958, to 4/24, 1962, that (H) (we) last saw the deceased alive on... 4/24, 1962, and that death occurred at 1:58 p.m. the causes and on the date stated above.

22a. SIGNATURE

Harry G. Butler

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

April 24, 1962

22c. PHYSICIAN'S NAME (Type)

Harry G. Butler, M.D.

22d. ADDRESS

Rosewood Lane, Owings Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL 4/27/62

23c. NAME OF CEMETERY OR CREMATORY

New CATHEDRAL BALTIMORE Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

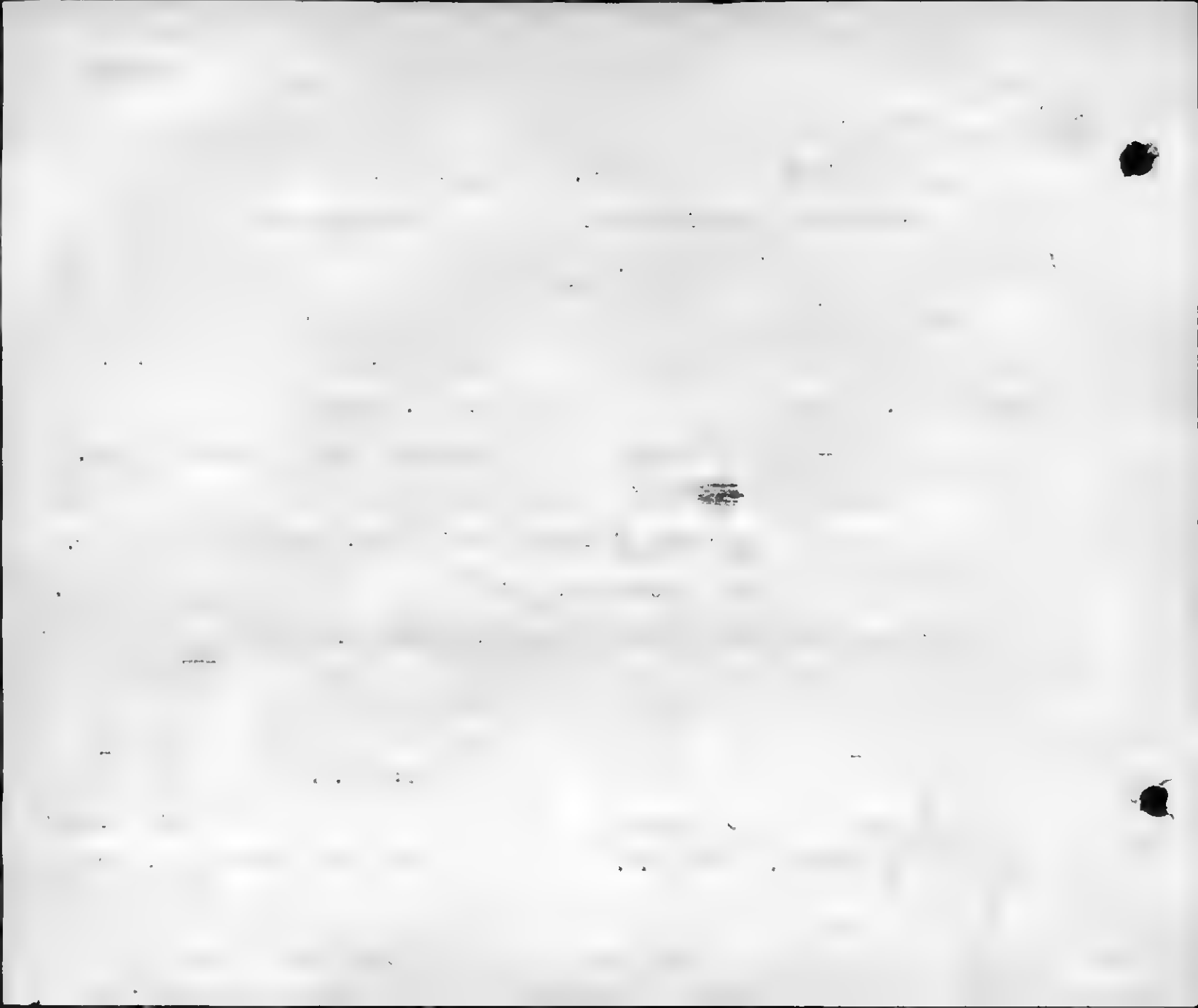
L. F. Ruck Inc 5305 Hanford Road

DATE APR 30 '62

William L. Harris

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst lnt on Residence before admission) a. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Catonsville		c. LENGTH OF STAY in lb		5 Months 4 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Spring Grove State Hospital		d. STREET ADDRESS		1124 W. Pratt Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		Albert D. Pocklington, Sr.		4. DATE OF DEATH		April 7, 1962					
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		PIPE COVERER		10b. KIND OF BUSINESS OR INDUSTRY		CONT		11. BIRTHPLACE (State or foreign country)		BALTO Md	
13. FATHER'S NAME		ALBERT D. Pocklington		14. MOTHER'S MAIDEN NAME		Margaret Hopwood					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war and dates of service)		No		16. SOCIAL SECURITY NO.		xyo-01-1471		17. INFORMANT		Christina O. Pocklington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchopneumonia with abscess formation				INTERVAL BETWEEN ONSET AND DEATH			
		DUE TO		General paresis							
		(b)									
		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		R. Breiteneker		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED		April 8, 1962	
EXAMINER'S NAME (Type)		R. Breiteneker, M. D.		Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)					
Burial		10 April 1962		Roudon Park Cem		BALTO Md					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
R. C. Walters		Pratt & Stricker St		APR 10 '62		Arthur S. Thomas					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician's office for 10 days after the death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

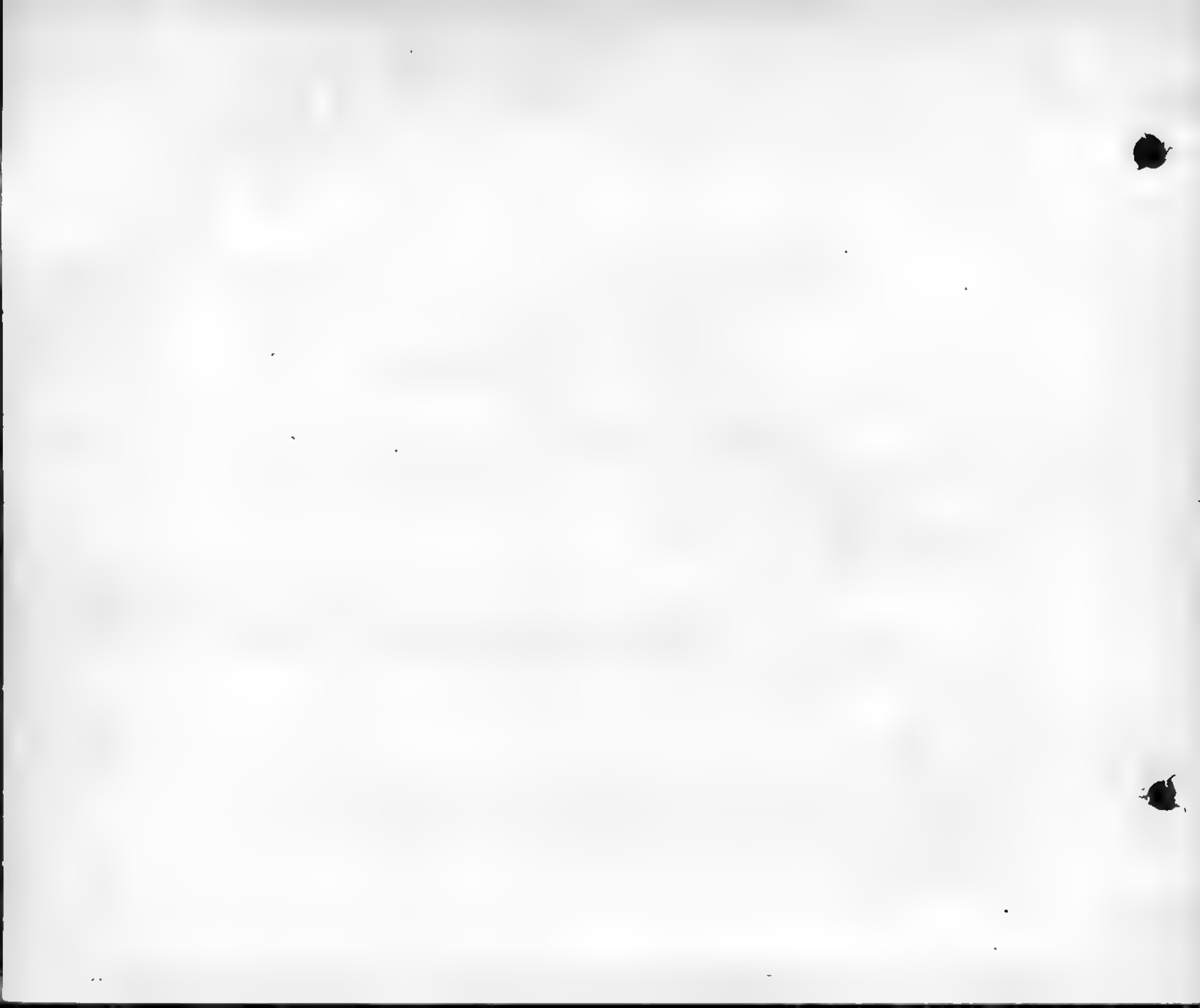
Items 12 & 14 filled 5/2/62 5:20 PM iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 01298

04301

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7500 DURWOOD RD.</u>				d. STREET ADDRESS <u>7500 DURWOOD RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANTHONY A PODLES</u>				4. DATE OF DEATH Month Day Year <u>4 24 1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 14 16</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLAZER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CAPLAN GLASS CO.</u>			
11. BIRTHPLACE (State or foreign country) <u>PAST CHRISTIAN MISS.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JACOB Podles</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-07-9045</u>			
17. INFORMANT Address <u>ANGELA PODLES 7500 DURWOOD RD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesothelioma Peritoneum</u>							
2300 X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u>							
(c) <u>Pulmonary Embolism - Histoplasmosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 1961</u> to <u>March 1962</u> , that I last saw the deceased alive on <u>March 13 1962</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Manuel P. de Leon</u> M.D.				ADDRESS (Street, city or town, state) <u>7840 Eastern Ave - Balt 24 Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>MANUEL P. DE LEON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/28/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halter Nahrawski</u> ADDRESS <u>1005 DUNDRAK AVE.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>		24b. REGISTRAR'S SIGNATURE <u>James R. King</u>	

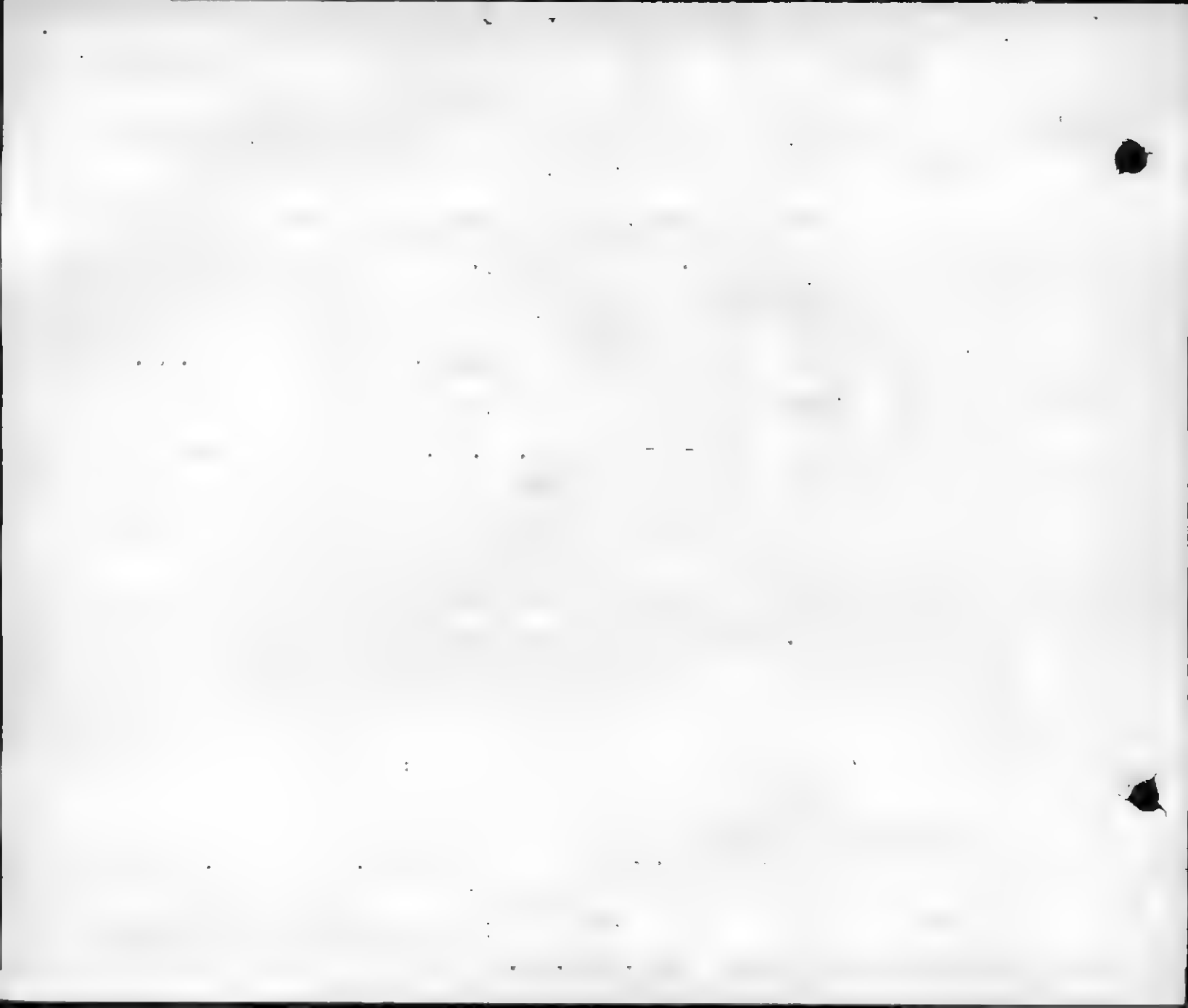


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

BP

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
04302		04299	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY	Baltimore	a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Fert Howard	b. COUNTY	Baltimore
c. LENGTH OF STAY IN 1b	3 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Randallstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Veterans Administration Hospital	d. STREET ADDRESS	9001 Liberty Road
3. NAME OF DECEASED (Type or print)	JOHN P. RAINEY, SR.	4. DATE OF DEATH	APRIL 8 1962
5. SEX	Male	6. COLOR OR RACE	White
7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	3/17/93
9. AGE (In years last birthday)	69 yrs.	10. BIRTHPLACE (County & State, or foreign country)	Baltimore, Maryland
11. CITIZEN OF WHAT COUNTRY?	U.S.A.	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	John Rainey	14. MOTHER'S MAIDEN NAME	Mary Connelly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	Yes WW I	16. SOCIAL SECURITY NO.	216-07-1558
17. INFORMANT	Clin. Rec. VAH, Fort Howard, Maryland	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	CIRRHOSIS OF LIVER
19. INTERVAL BETWEEN ONSET AND DEATH	UNKNOWN	20. CHRONIC USE OF ALCOHOL	UNKNOWN
21. MAINUTRITION. PEPTIC ULCER		22. MAINUTRITION. PEPTIC ULCER	
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY	Month, Day, Year	26. INJURY OCCURRED	27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
28. (City or town)	(County)	29. (State)	
30. I certify that (if this hospital) attended the deceased from April 5 1962 to April 8 1962, that (we) last saw the deceased alive on April 8 1962, and that death occurred at 2:15 AM from the causes and on the date stated above.		31. SIGNATURE	Daniel R. Zoll, M.D.
32. PHYSICIAN'S NAME (Type)	DANIEL R. ZOLL, M.D.	33. ADDRESS	VA HOSPITAL, FORT HOWARD, MARYLAND
34. BURIAL, CREMATION, REMOVAL (Specify)	4/11/62	35. NAME OF CEMETERY OR CREMATORY	New Cathedral Cemetery
36. DATE THEREOF	4/11/62	37. LOCATION (City, town or county)	Baltimore, Maryland
38. FUNERAL DIRECTOR'S SIGNATURE	Ellsworth Armacost	39. REC'D BY REGISTRAR	APR 9 '62
40. ADDRESS	Ellsworth Armacost Funeral Chapel, Balto. Md.	41. REGISTRAR'S SIGNATURE	Arthur S. Harris



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

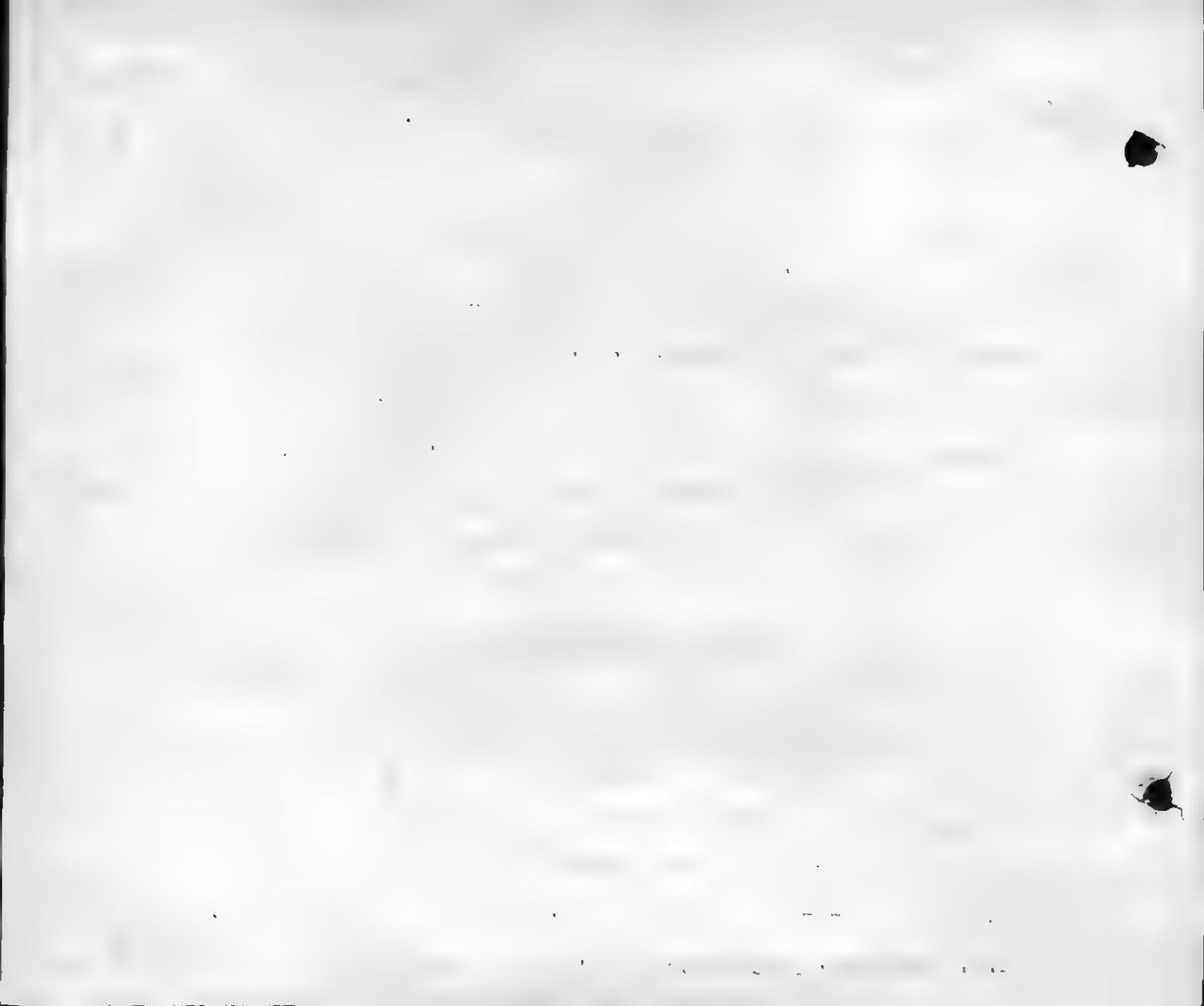
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04303

04310

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1227 Willow Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Dundalk</u> c. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) <u>1227 Willow Road</u> d. STREET ADDRESS <u>1227 Willow Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Owen E. Ramey</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-12-1922</u> 9. AGE (in years) <u>39</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>29</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>62</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor (freight)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. R. R.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Ramey</u> 14. MOTHER'S MAIDEN NAME <u>Grace Ann Frye</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>218161299</u> 17. INFORMANT <u>Rosalie G. Ramey</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bulbar Polio (1952)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>4/26</u> <u>1962</u> to <u>4/29</u> <u>1962</u> that (I) <u>was</u> last saw the deceased alive on <u>4/29</u> <u>1962</u> and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Ronald E. Keyser, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>RONALD E. KEYSER, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>4016 WOODRIDGE RD. BALTO. 29 MD.</u> 22b. DATE SIGNED <u>30 APRIL 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>5-2-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Belair Mem. Gardens</u> 23d. LOCATION (City, town or county) <u>Belair, Md.</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc.</u> ADDRESS <u>5305 Harford Rd.</u> 25a. REC'D BY REGISTRAR <u>MAY 4 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04301

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1011 Letitia Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> <u>ONAY</u> <u>Razgaitis</u> First Middle Last		4. DATE OF DEATH <u>April 15 1962</u> Month Day Year	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1876</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR (CONT. MAKER)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>LITHUANIA</u> 11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>215-23-5707</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address <u>---</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> (b) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u> 20f. (City or town) (County) (State) <u>---</u>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 23, 1962</u> to <u>April 15, 1962</u> that (I) (we) last saw the deceased alive on <u>April 15, 1962</u> , and that death occurred at <u>---</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachler</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachler M. D.</u>		22b. DATE SIGNED <u>4-16-62</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 26, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/18/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u> 23d. LOCATION (City, town or county) (State) <u>BELAIR RD - MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Fachanston</u> 25. REC'D BY REGISTRAR <u>---</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> DATE <u>APR 18 1962</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

72

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

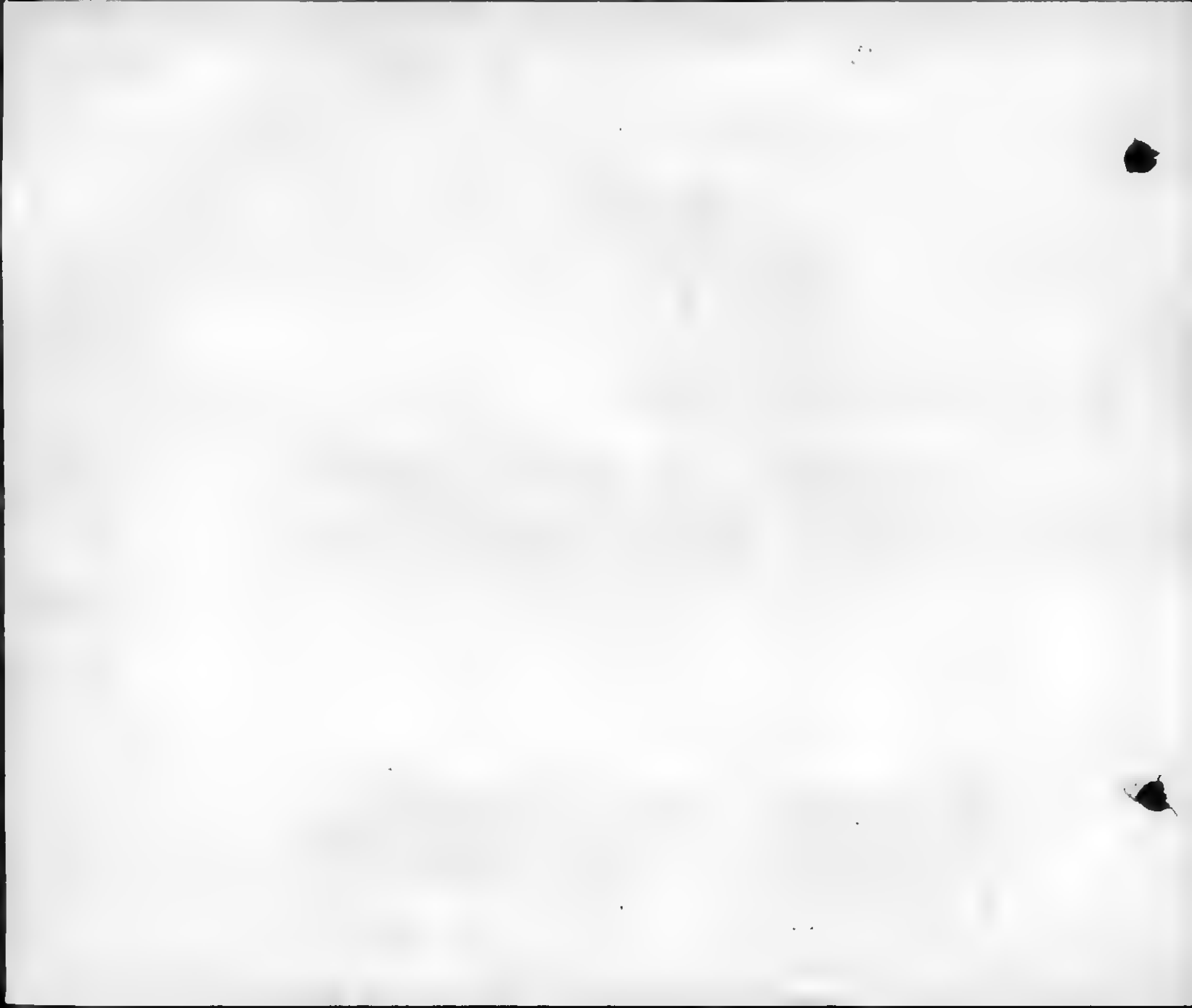
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04302

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b HOME d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RIDGEWAY MANOR CONVALESCENT		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MD b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO d. STREET ADDRESS 4736 FREDERICK AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY W. REA		4. DATE OF DEATH APR. 21, 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 4, 1860
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R. WHOLEY		14. MOTHER'S MAIDEN NAME ELIZABETH PEASTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT MR. JOSEPH B. REA (SON)		Address 4736 FREDERICK AVE, BALTO, 29, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cerebrovascular Disease & Cerebral Thrombosis (c) Cerebral Thrombosis PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) -		INTERVAL BETWEEN ONSET AND DEATH 4/14/62 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/19 to 4/21 , 19 62 , that (I) (we) last saw the deceased alive on 4/19 , 19 62 , and that death occurred at 4:40 AM, from the causes and on the date stated above.			
22a. SIGNATURE Eliot W. Johnson		22b. DATE SIGNED 4/21	
22c. PHYSICIAN'S NAME (Type) Eliot W. Johnson		22d. ADDRESS 3432 Frederick Ave. Baltimore 29, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/24/62	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION (City, town or county) (State) PITESVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR APR 26 '62	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

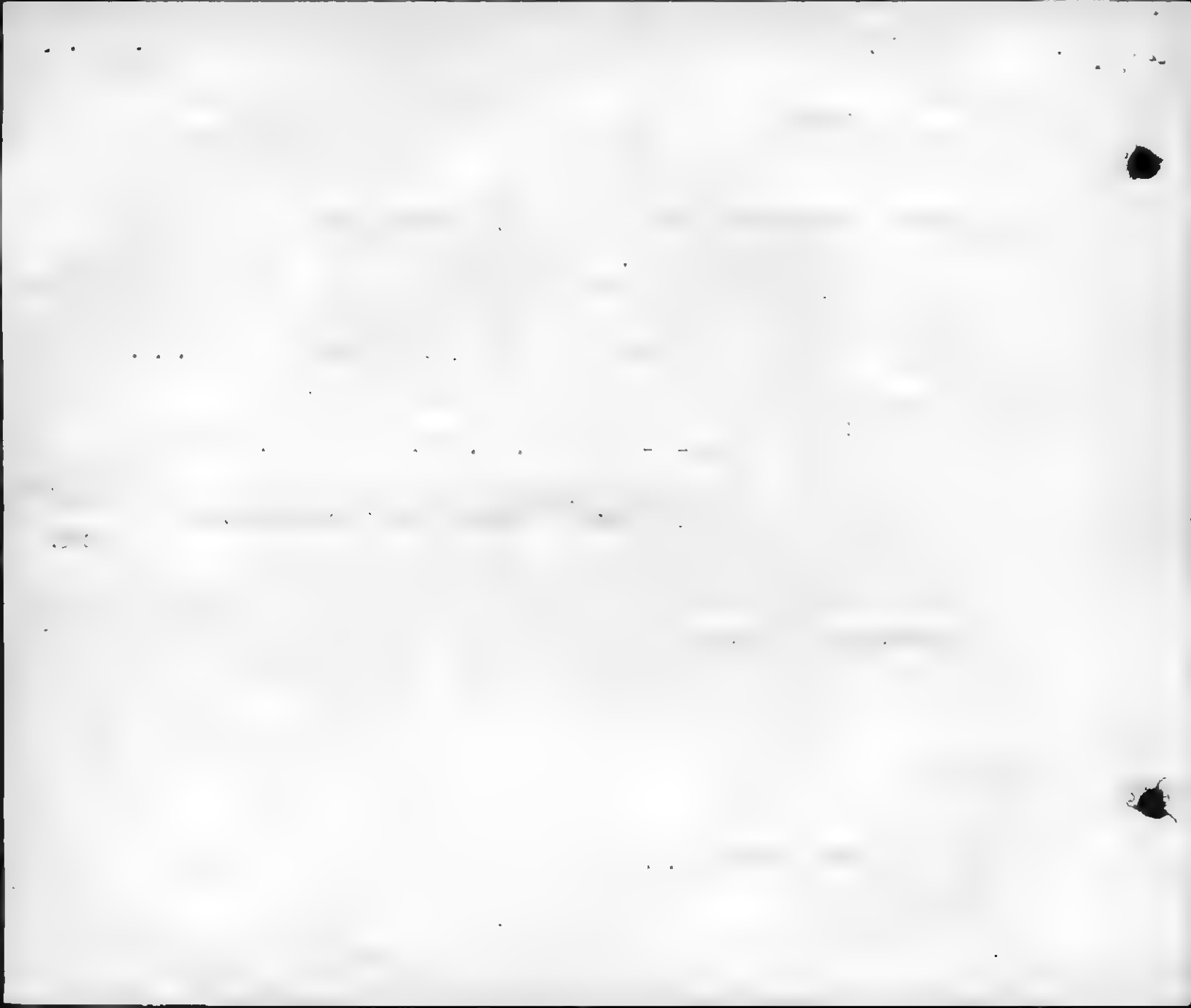


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04306
04303
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, <u>Fort Howard</u>)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marriottsville</u>	
c. LENGTH OF STAY IN TB <u>9 Days</u>		d. STREET ADDRESS <u>Ridge Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print, First Middle Last) <u>RAYMOND S. REID</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25TH</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/95</u>
9. AGE (In years (If UNDER 1 YEAR last birthday) Months Days Hours Min. <u>67 yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Newport, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Reid</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Elliott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>235-12-5809</u>	
17. INFORMANT <u>Clin.Rec. VAH, Fort Howard, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-C-1</u> DUE TO <u>MYOCARDIAL INFARCTION</u> HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 MINUTES</u> <u>UNDET.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophy of Prostate</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>April 16, 1962</u> Hour a.m. <u>7:50 AM</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH, FORT HOWARD, MARYLAND</u>		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>April 16, 1962</u> to <u>April 25, 1962</u> , that (we) last saw the deceased alive on <u>April 25, 1962</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Irving Freeman</u>		22b. DATE SIGNED <u>4/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS <u>VAH, FORT HOWARD, MARYLAND</u>		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-27-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, 6009 Harford Road, Baltimore 14</u>		25a. REC'D BY REGISTRAR <u>APR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight</u>		25c. REGISTRAR'S SIGNATURE	



04307

MEDICAL CERTIFICATION

VS A15 (4)
ISM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04305

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>24yr8mtl1dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>310 S. Broadway - June 31</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> f. DATE OF DEATH <u>April 2, 1962</u>			
3. NAME OF DECEASED (Type or print) <u>Frances Roberts</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
5. SEX <u>female</u>		8. DATE OF BIRTH <u>Aug. 19, 1881</u>		9. AGE (in years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS.: Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Germany</u>			
12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>		13. FATHER'S NAME <u>Joseph Kleis</u>					
14. MOTHER'S MAIDEN NAME <u>Mary</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>unknown</u>					
16. SOCIAL SECURITY NO. <u>705-09-1373</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro - Vasc. Accident</u> (b) <u>Arterioscl. Cardio Vasc. Disease</u> (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>							
20c. TIME OF INJURY Month, Day, Year <u>July 21, 1937</u> Hour a.m. <u>4/2</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) (County) (State) <u>-</u>			
21. I certify that (this hospital) attended the deceased from <u>July 21, 1937</u> to <u>4/2, 1962</u> that (I) (we) last saw the deceased alive on <u>4/2, 1962</u> and that death occurred at <u>325 M</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.		22b. DATE SIGNED <u>4/2/62</u>		22c. PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>			
22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		23a. LOCATION (City, town or county) (State) <u>Catonsville 28, Md.</u>					
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23c. DATE THEREOF <u>4/2/62</u>		23d. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u>		25a. REC'D BY REGISTRAR <u>APR 3 '62</u>		25b. REGISTRAR'S SIGNATURE <u>John E. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04309									
04306									
Item 9 Film G312 5/4/62 iwk									
1. PLACE OF DEATH a. COUNTY BALTO.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO.		c. LENGTH OF STAY IN 1b 2 M. 24 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD		b. COUNTY BALTO.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 3708 CRANSTON AVE.		g. DATE OF DEATH 4 22 1962		h. AGE (in years last birthday) 44 yrs	
3. NAME OR DECEASED (Type or print) MARY BERNICE		4. SEX F		5. COLOR OR RACE W		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH 4/8/88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Sales lady		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH ROEDER	
14. MOTHER'S MAIDEN NAME ROSA KATHMAN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216012653A		17. INFORMANT CARROLL R. ROEDER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Arteriosclerotic heart disease		DUE TO Generalized arteriosclerosis		DUE TO Decubital gangrene and toxemia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) SPRING GROVE STATE HOSPITAL		20g. (County) BALTO		20h. (State) MD	
21. I certify that (this hospital) attended the deceased from Jan. 30 8:15 to April 22 1962 that (we) last saw the deceased alive on April 22 1962 , and that death occurred at 8:15 P. from the causes and on the date stated above.		22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 4-23-62		22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/26/62		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) BALTIMORE		23e. (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE J. Ruck Inc		24a. ADDRESS 5305 HARTFORD Rd.		24b. DATE APR 30 '62		24c. REGISTRAR'S SIGNATURE Arthur L. Kline		24d. DATE APR 30 '62	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04310

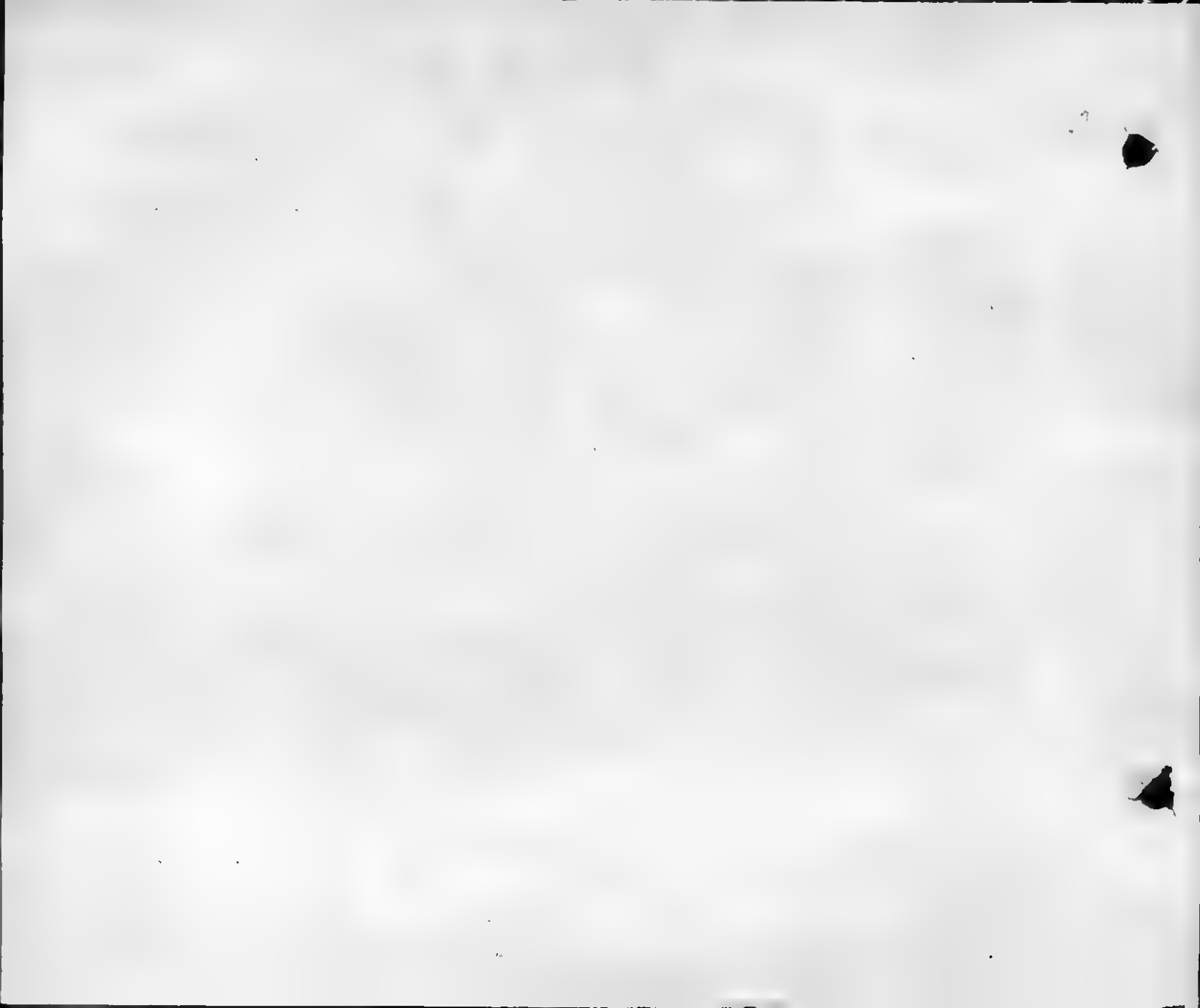
CERTIFICATE OF DEATH

04307

Item 2 Film 0311 4/24/62 mb

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN b. <u>5 mo.</u>		d. STREET ADDRESS <u>22 S. Athol St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Joseph Rogers</u>		4. DATE OF DEATH <u>4-8-1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (Country & State or foreign country) <u>H. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>H. S. A.</u>	
13. FATHER'S NAME <u>Patrick Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Mary O'Donnell</u>	
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>072-03-1767</u>	
17. INFORMANT <u>Joseph S. Porta - Spring G. State Hosp.</u>		Address <u>Spring G. State Hosp.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF ACCIDENT, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>10-20-1961</u> to <u>4-8-1962</u> that (we) last saw the deceased alive on <u>4-8-1962</u> and that death occurred at <u>2:58</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga, M.D.</u>		22b. DATE SIGNED <u>4-8-1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>SPRING GROVE STATE HOSP.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSP.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>BURIAL</u> <u>4-11-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	
23d. LOCATION (City, town or county) <u>Baltimore</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.,</u>		25a. REC'D BY REGISTRAR <u>APR 10 '62</u>	
ADDRESS <u>1050 York Road, TOWSON 4 Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

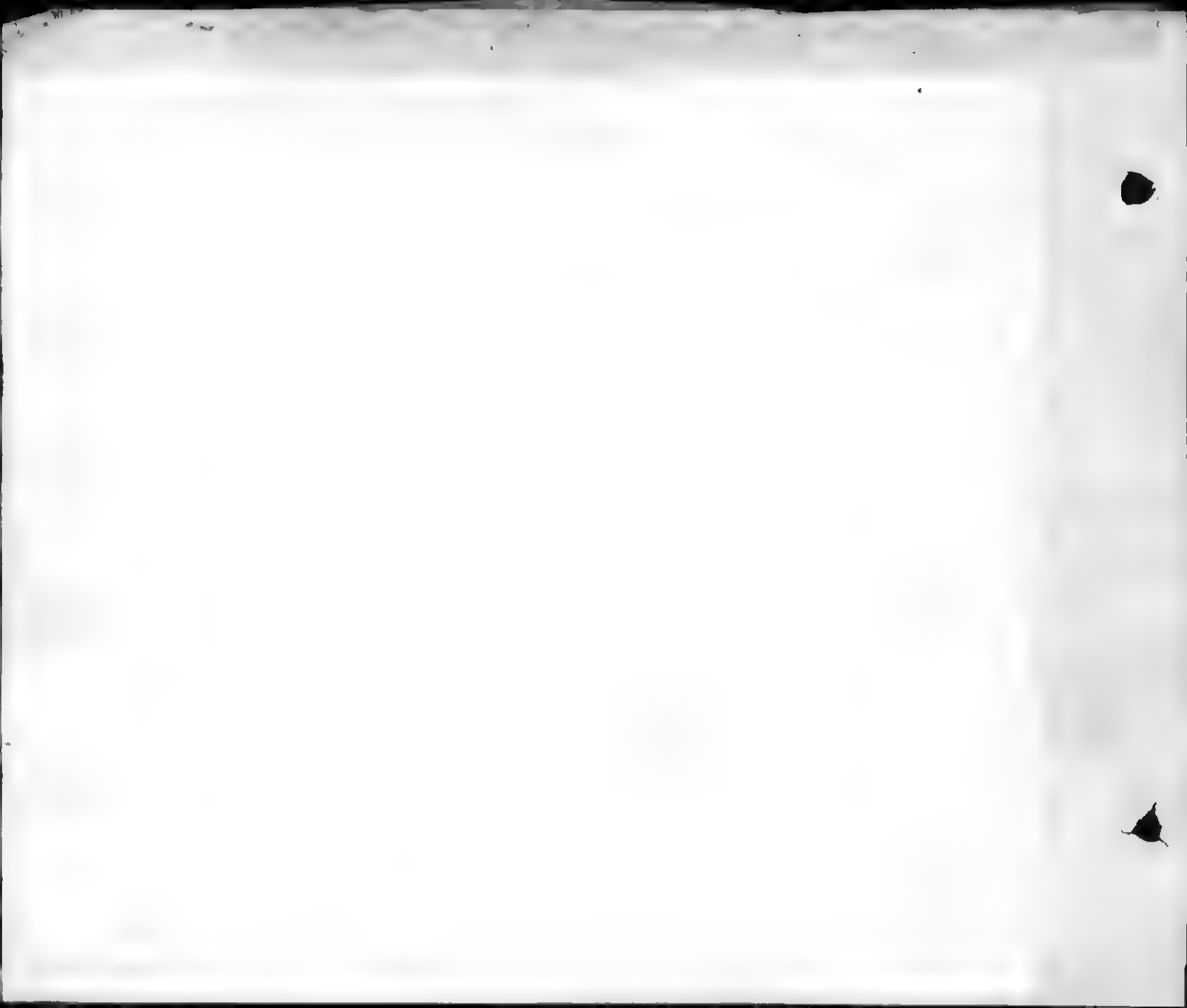
CERTIFICATE OF DEATH

1 NAME OF DECEASED (Type or Print)		2 DATE OF DEATH	
Henry J. Rommel		04/30/62	
3 PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Calverton House In The Pines Nursing Home		4 USUAL RESIDENCE Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY Md. 26-09 C. CITY OR TOWN Baltimore D. STREET ADDRESS 602 South Grundy St.	
5 SEX male	6. COLOR OR RACE white	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8 DATE OF BIRTH 5-1-1885
9 AGE (In years last birthday) 76		10 If Under 1 Yr. If Under 24 Hrs Months Days Hours Min	
10A USUAL OCCUPATION Give end of work done during most of working life even if retired Ret. Watchman		10B KIND OF BUSINESS OR INDUSTRY Cont. Can Co.	
11 BIRTHPLACE Maryland		12 CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John August Rommel		14 MOTHER'S MAIDEN NAME Elizabeth Sonn	
15 Was Deceased Ever in U. S. Armed Forces? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Rommel		ADDRESS 2704 Wooddale Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420-1 Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		B. Gouty Arthritis	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE		C.	
21D TIME OF INJURY (Month) (Day) (Year) (Hour) 4/16 1962		21E INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from 4/16 1962 to 4/13 1962, that (1) (we) last saw the deceased alive on 4/13 1962 and that in (my) (our) opinion death occurred at 2:45 p.m. from the causes and on the date stated above		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE H. J. Rommel M.D.		23B ADDRESS 3400 E. Belts W	
23C DATE SIGNED 4/17/62		24. LOCATION (City town or county) (State) Baltimore, Md.	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 4-19-62	
24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery		24D. LOCATION (City town or county) (State) Baltimore, Md.	
25A. DATE RECD BY HEALTH DEPT. APR 17 1962		25B. NAME OF REG. STRAR Arthur H. Williams, M.D.	
25C. FUNERAL DIRECTOR J. Ruck Inc.		ADDRESS 3305 Harford Rd.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

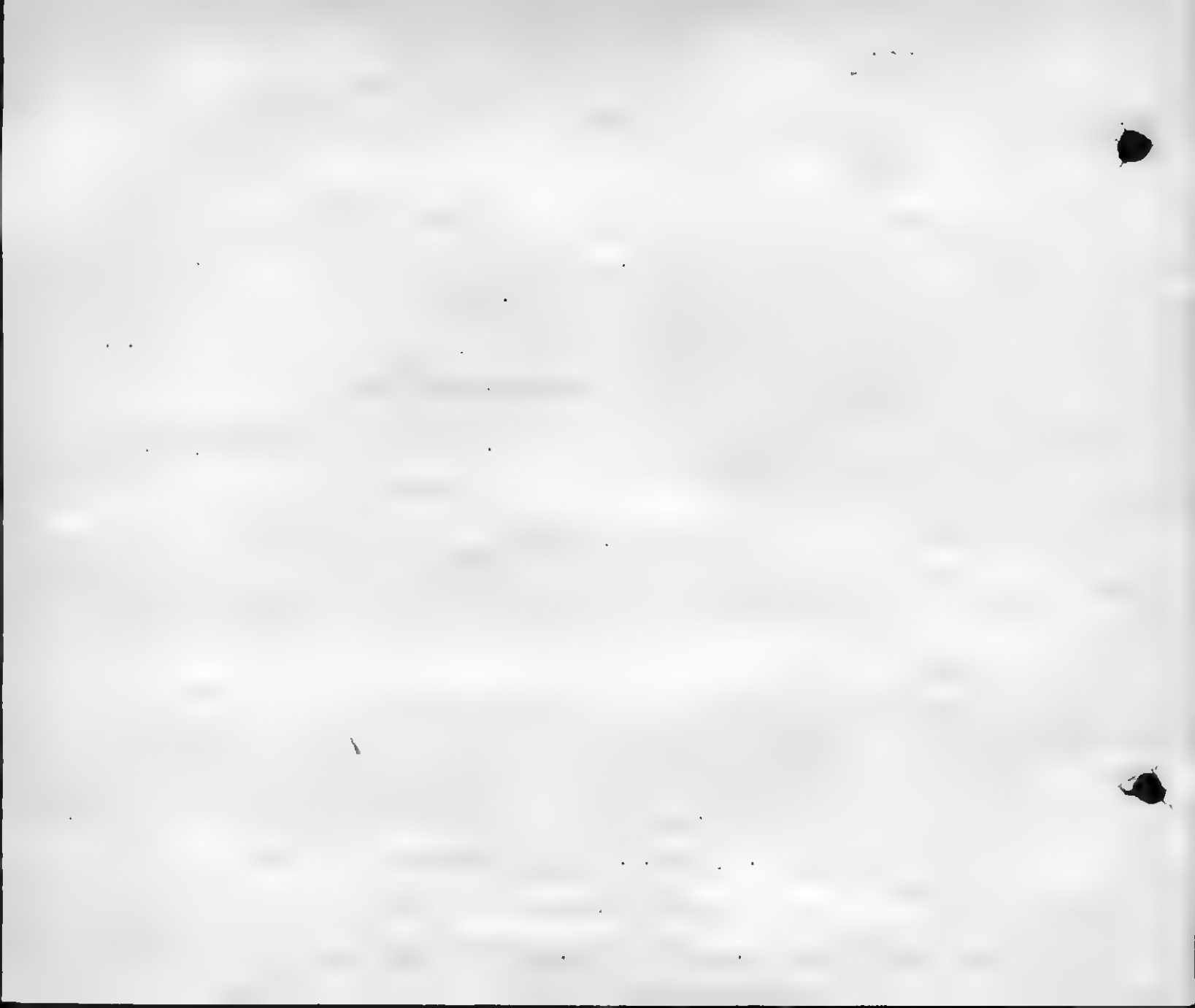
VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04312		CERTIFICATE OF DEATH						04309			
1. PLACE OF DEATH a. COUNTY Baltimore				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Arm				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Arm d. STREET ADDRESS Long Green Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Long Green Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lillian Catherine Russell				4. DATE OF DEATH Month April Day 21 Year 1962							
5. SEX F				6. COLOR OR RACE W				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Aug. 15, 1902				9. AGE (in years last birthday) 59 yrs.				10. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Baltimore County Maryland				11. PLACE OF BIRTH (County & State, or foreign country) U.S.A.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Arthur R. Clayton				14. MOTHER'S MAIDEN NAME Lilly Dilworth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Elmer L. Russell, Long Green Road, Glen Arm, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) As above (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Sept. 1961 to April, 1962 that (I) (we) last saw the deceased alive on 4-21-1962 and that death occurred at 9:45 PM, from the causes and on the date stated above.											
22a. SIGNATURE William A. Tyson				22b. DATE SIGNED 4-21-62							
22c. PHYSICIAN'S NAME (Type) William A. Tyson, M.D.				22d. ADDRESS Kingsville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 4-24-62				23c. NAME OF CEMETERY OR CREMATORY Fork Methodist Church Cemetery, Fork, Maryland			
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc., 1050 York Rd. Towson 4				25a. REC'D BY REGISTRAR DATE APR 24 '62				25b. REGISTRAR'S SIGNATURE Wm. L. Thomas			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04313

CERTIFICATE OF DEATH

05543

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Herrwood, Randallstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Herrwood, Randallstown, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marriottsville Road		d. STREET ADDRESS Marriottsville Road	
3. NAME OF DECEASED (Type or print) Mrs. Frances Hunter		4. DATE OF DEATH Month April Day 14 Year 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1877	
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Mahala Woodward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Mary J. Saumenig,		Address Marriottsville Road Randallstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Fracture DUE TO (b) Suppurative Head Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from OCT. 22, 1957 to April 14, 1962 ; that (I) (we) last saw the deceased alive on April 13, 1962 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. 22a. SIGNATURE Edwin L. Pierpont M.D. 22b. DATE SIGNED April 14, 1962 22c. PHYSICIAN'S NAME (Type) Dr. Edwin L. Pierpont 22d. ADDRESS 8204 Liberty Rd., Baltimore 7, Maryland 23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 4-17-62 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers 25a. REC'D BY REGISTRAR APR 19 62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



04314

CERTIFICATE OF DEATH

Reg. Dist. No. 04310

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 223 Falls Brook Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle VERONICA Last SCHAEFFER		4. DATE OF DEATH Month April Day 10 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/84
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Vilma Theatre	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Horstschneider		14. MOTHER'S MAIDEN NAME Anna Watter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Carnes, dght, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic cardiac disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-5 , 19 62 , to 4-10 , 19 62 , that I last saw the deceased alive on 4-9 , 19 62 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John J. Gould M.D.			
PHYSICIAN'S NAME (Type) JOHN J. GOULD		1472 Federal Ave Baltimore - 24 2004	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/13/62	Gardens of Faith	Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS 3331 Brehms Lane	
24a. REC'D BY REGISTRAR DATE APR 12 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

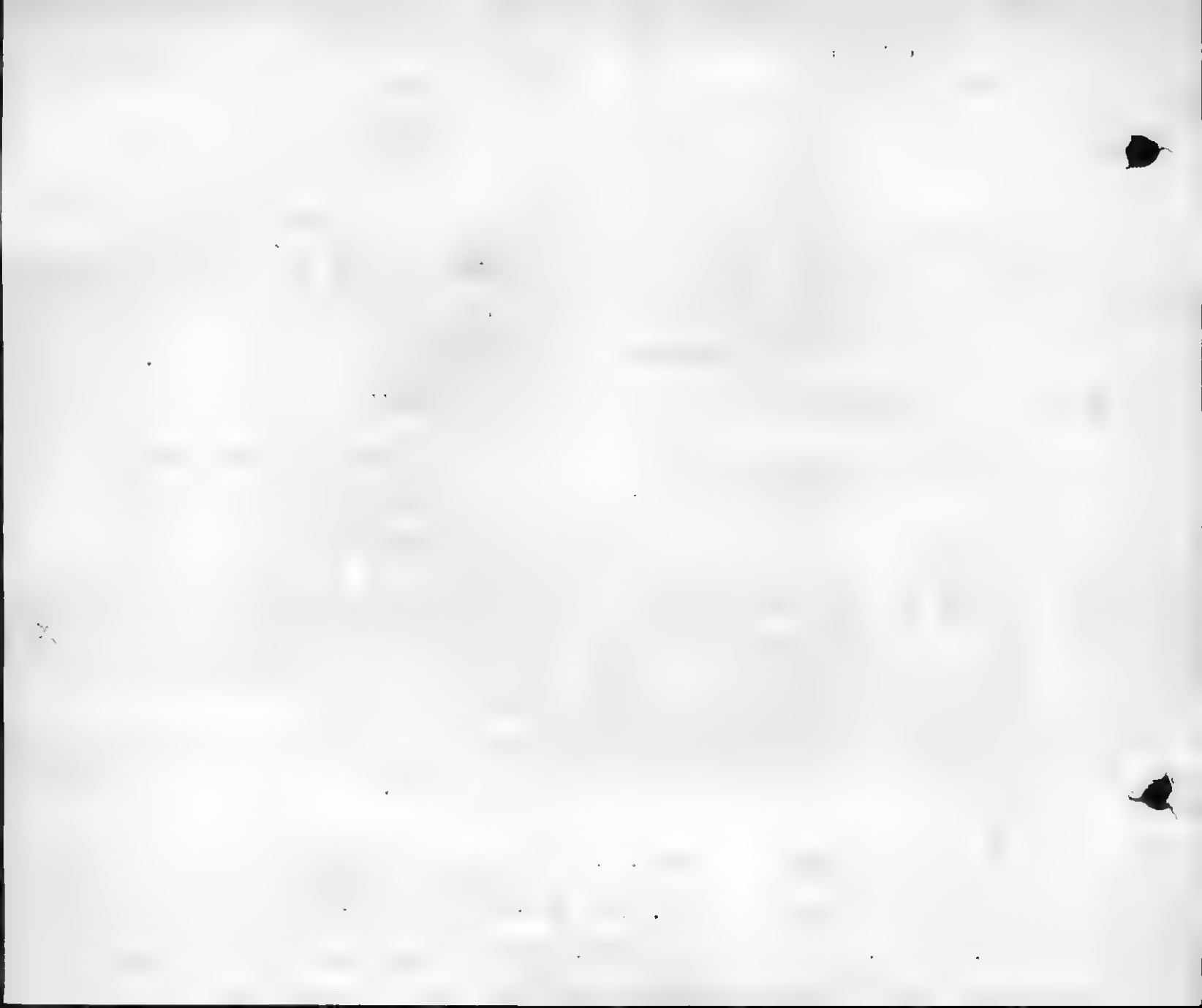


TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04315					04311				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>2yr2mth25dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Eastern</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 29 d. STREET ADDRESS <u>1023 Elmridge Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Henrietta</u> Last <u>Schmidt</u>					4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1962</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15, 1883</u> 78 yrs.		9. AGE (in years last birthday) <u>78</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown (none)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>August Clay</u>					14. MOTHER'S MAIDEN NAME <u>Louisa Sonn</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>					16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> +22.2 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis, severe</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from <u>Jan. 15, 1960</u> to <u>April 10, 1962</u> , that it (we) last saw the deceased alive on <u>April 10, 1962</u> , and that death occurred at <u>11:30 P.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Stella Wachler</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-11-62		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Parkville</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u> ADDRESS					25a. REC'D BY REGISTRAR <u>APR 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04312

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

X

I

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 8326 Bletzer Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8326 Bletzer Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA MARIE Middle SCHOEFFIELD Last				4. DATE OF DEATH Month April Day 24 Year 19 62			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1893		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ludwig Grill				14. MOTHER'S MAIDEN NAME Theresa Fuchs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Schoeffield, husband, above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4200 DUE TO (b) A-S-C-V-DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M B Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/25/62	
EXAMINER'S NAME (Type) M. B. Davis				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 4/27/ 62		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane				ADDRESS Funeral Home		24a. REC'D BY REGISTRAR APR 26 '62 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04317

04313

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6322 Sherwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>6322 Sherwood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ornelius Schriver</u> (Schriver) Sr. 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 2, 1882</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Cement Finisher</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard Schriver</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Reilly</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>Bertha Schriver</u> 17. INFORMANT <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/13</u> , 19 <u>61</u> , to <u>4/22</u> , 19 <u>62</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/25</u> , 19 <u>62</u> , and that death occurred at <u>6:45</u> PM, from the causes and on the date stated above. 22a. SIGNATURE <u>W. M. Smith</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/27/62</u> 22c. PHYSICIAN'S NAME (Type)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>4-30-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc 5305 Harford Road</u> ADDRESS 25a. REC'D BY REGISTRAR DATE <u>MAY 4 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04318

04314

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Catonsville**
c. LENGTH OF STAY IN It
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) **208 S. Symington Ave Apt B**

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE **Md** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) **Catonsville**
d. STREET ADDRESS **208 Symington Ave Apt B**

3. NAME OF DECEASED (Type or print) **Arthur Walter Schwarz**
4. SEX **Male** 5. RACE **White** 6. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **Oct. 5, 1891** 9. AGE (In years, if under 1 year, last birthday) **70** yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Salesman- West Chemical Products Co** 11. BIRTHPLACE (State or foreign country) **Baltimore, Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Schwarz** 14. MOTHER'S MAIDEN NAME **Christinia**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO **212-03-3315** 17. INFORMANT **Mrs. Ottilia Schwarz** Address **208 S. Symington Ave.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). **Coronary thrombosis**
DUE TO **4-26-62**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **1**
DUE TO **(b)**
DUE TO **(c)**
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

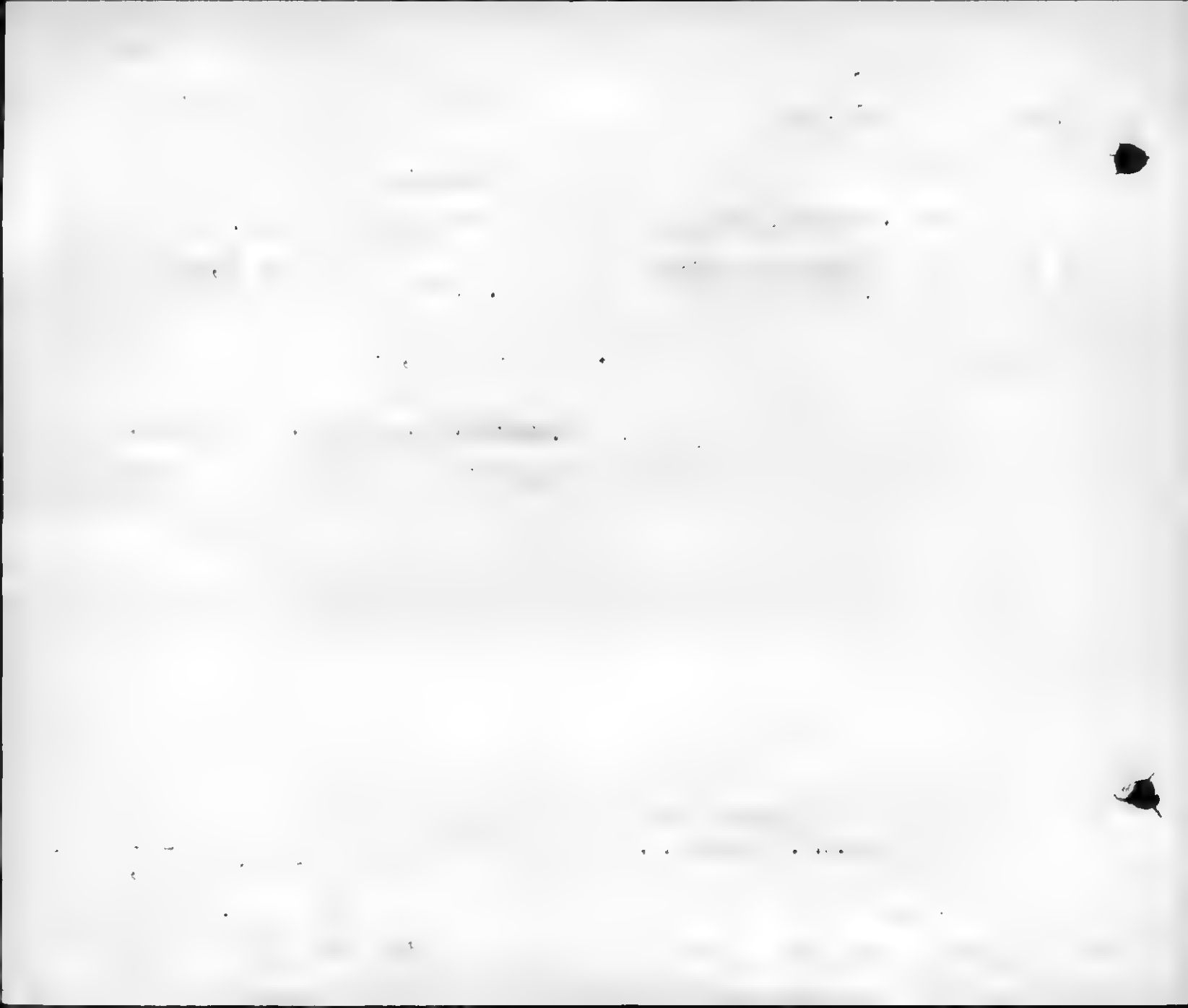
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 **19** 20d. INJURY OCCURRED White ☒ Not White ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.) 20f. City or town (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE **Geo. S. M. Kieffer** DATE SIGNED **4-26-62**
EXAMINER'S NAME (Type) **Geo. S. M. Kieffer M.D.** Address (Street city, town or county) **1010 Leads Ave.** (State)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **4-30-62** 22c. NAME OF CEMETERY OR CREMATORY **Woodlawn Cemetery** 22d. LOCATION (City, town, or county) **Baltimore, Md.**

23. FUNERAL DIRECTOR **Wm J. Suckewaldson** ADDRESS **Balto 17, Md** 24a. REC'D BY REGISTRAR **APR 30 '62** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kneass**

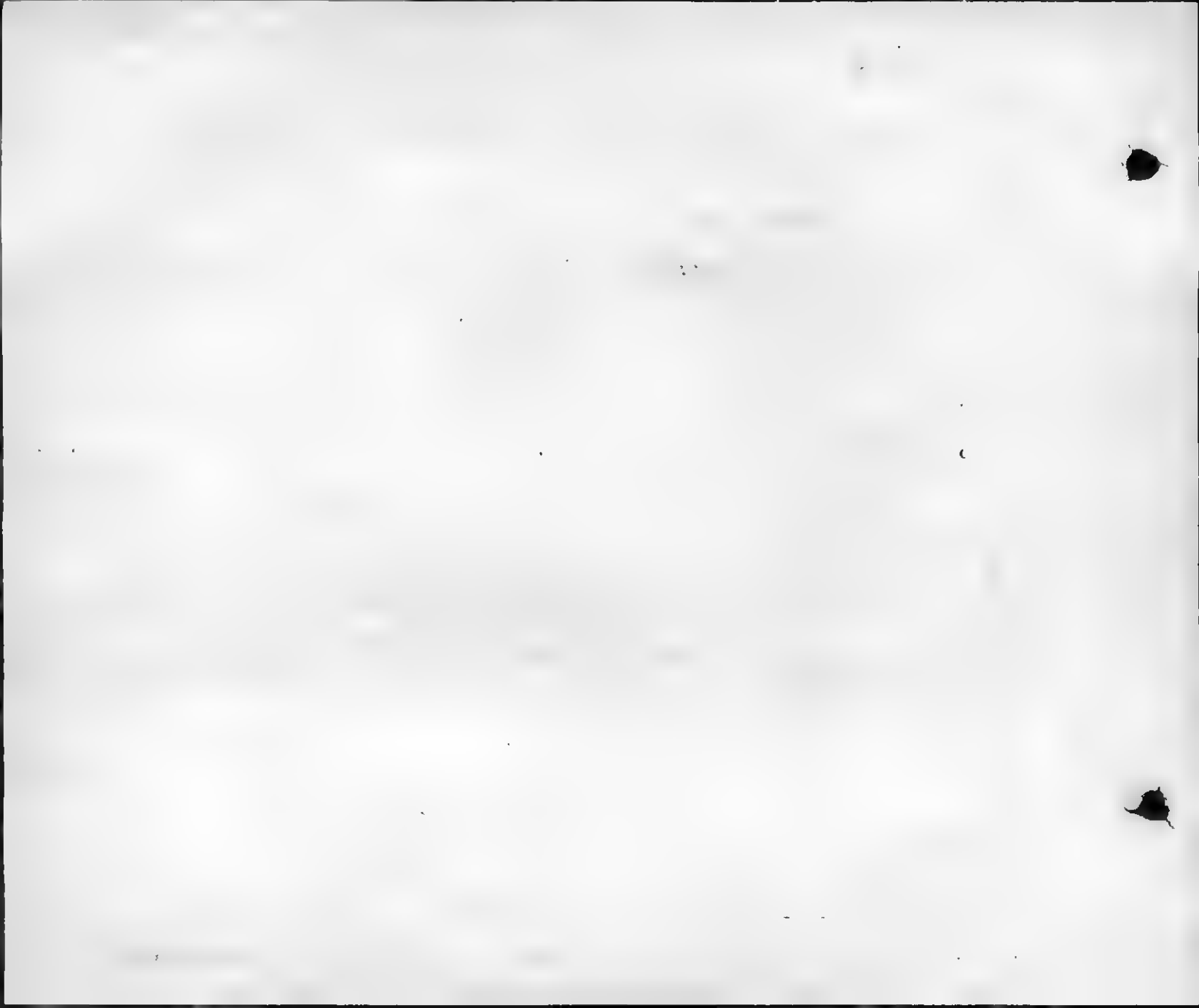


TO HOSPITAL
TO FUNERAL DIRECTOR:
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04319
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04315
04319
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN b. <u>12</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>805 Wellington Road #12</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> h. STREET ADDRESS <u>805 Wellington Road #12</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Esther E. Schwarz</u> 4. DATE OF DEATH <u>April 15, 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>March 2, 1901</u> 9. AGE (In years last birthday) <u>61</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Minnesota</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank Elm</u> 14. MOTHER'S MAIDEN NAME <u>Emma Hawkins</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>163</u> 17. INFORMANT <u>Mrs. Judy Burkley-805 Wellington Road-Balto. 12, Md.</u> Address <u>805 Wellington Road-Balto. 12, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>2 yrs.</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>6-17-62</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-17-62</u> to <u>4-15-62</u> , that (I) (we) last saw the deceased alive on <u>4-14-62</u> , and that death occurred at <u>4-15-62</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Charles O'Donnell</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles O'Donnell</u> 22b. DATE SIGNED <u>4-16-62</u> 22d. ADDRESS <u>7501 York Road</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-17-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Truid Ridge Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Pikesville, Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker & Son</u> 25a. REC'D BY REGISTRAR <u>DATE apr 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04316

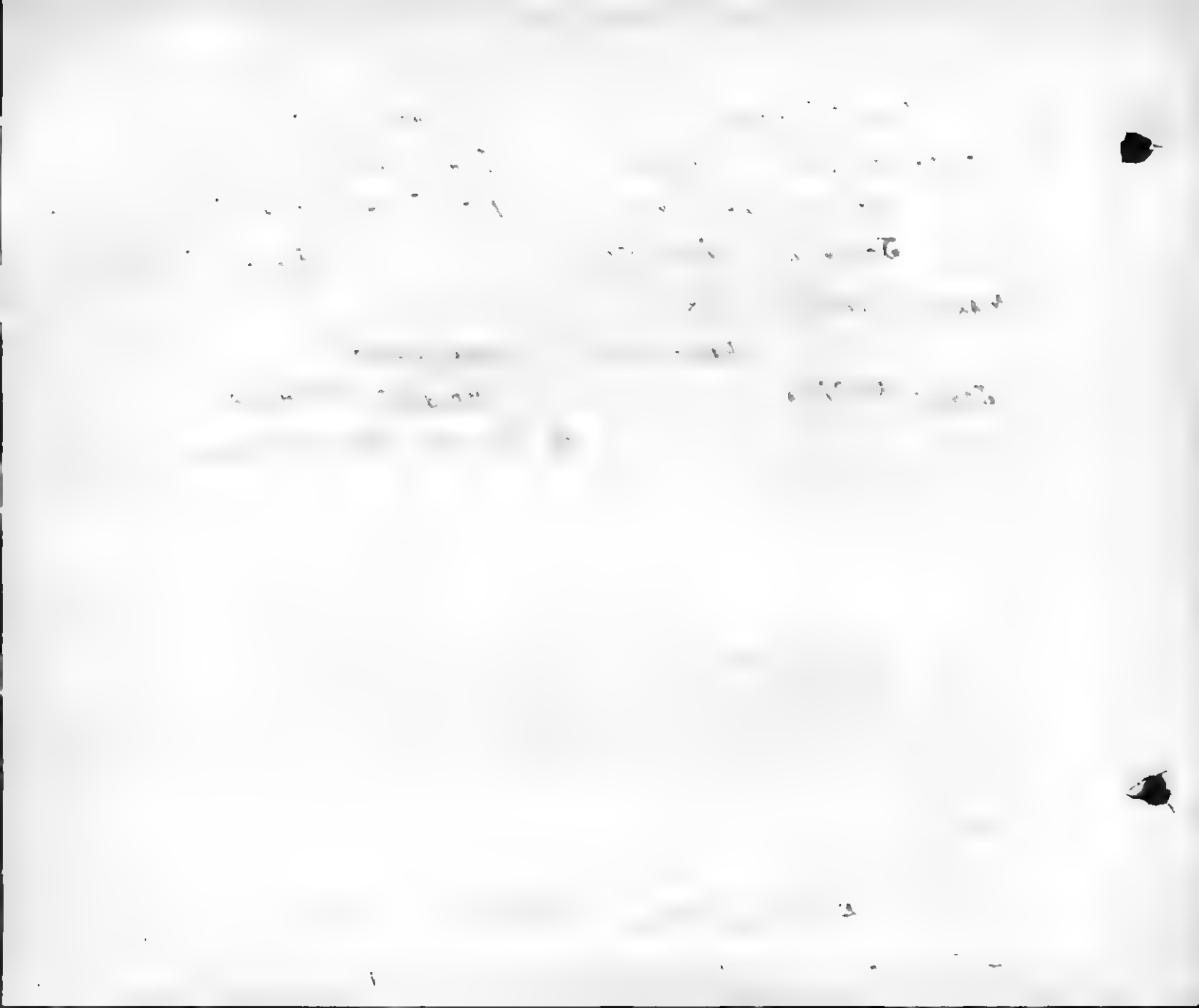
Reg. Dist. No.

04320

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND COUNTY - ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY in 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3401-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines				d. STREET ADDRESS 115 S. Augusta Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John J. Shea Sr. First Middle Last				4. DATE OF DEATH April 18, 1962 19 19 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/1878	
9. AGE (in years last birthday) 84 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R. SHEA				14. MOTHER'S MAIDEN NAME Bridget McAvory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) - (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mr. John J. Shea 919 Lynvue Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 PM							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July, 1952 to APRIL 18, 1962 that I last saw the deceased alive on APRIL 17, 1962 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert W. Lapp, M.D. 4804 FREDERICK AVE. M.D. BALTIMORE 29, MD. — MI 4-3655				ADDRESS (Street, city or town, state) 4804 Frederick Ave DATE SIGNED 4/18/62			
PHYSICIAN'S NAME (Type) Herbert W. Lapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/21/1962		22c. NAME OF CEMETERY OR CREMATORY New. Cathedral		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schwab ADDRESS 3512 Fred. Ave.				24a. REC'D BY REGISTRAR DATE APR 23 '62		24b. REGISTRAR'S SIGNATURE Wm S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

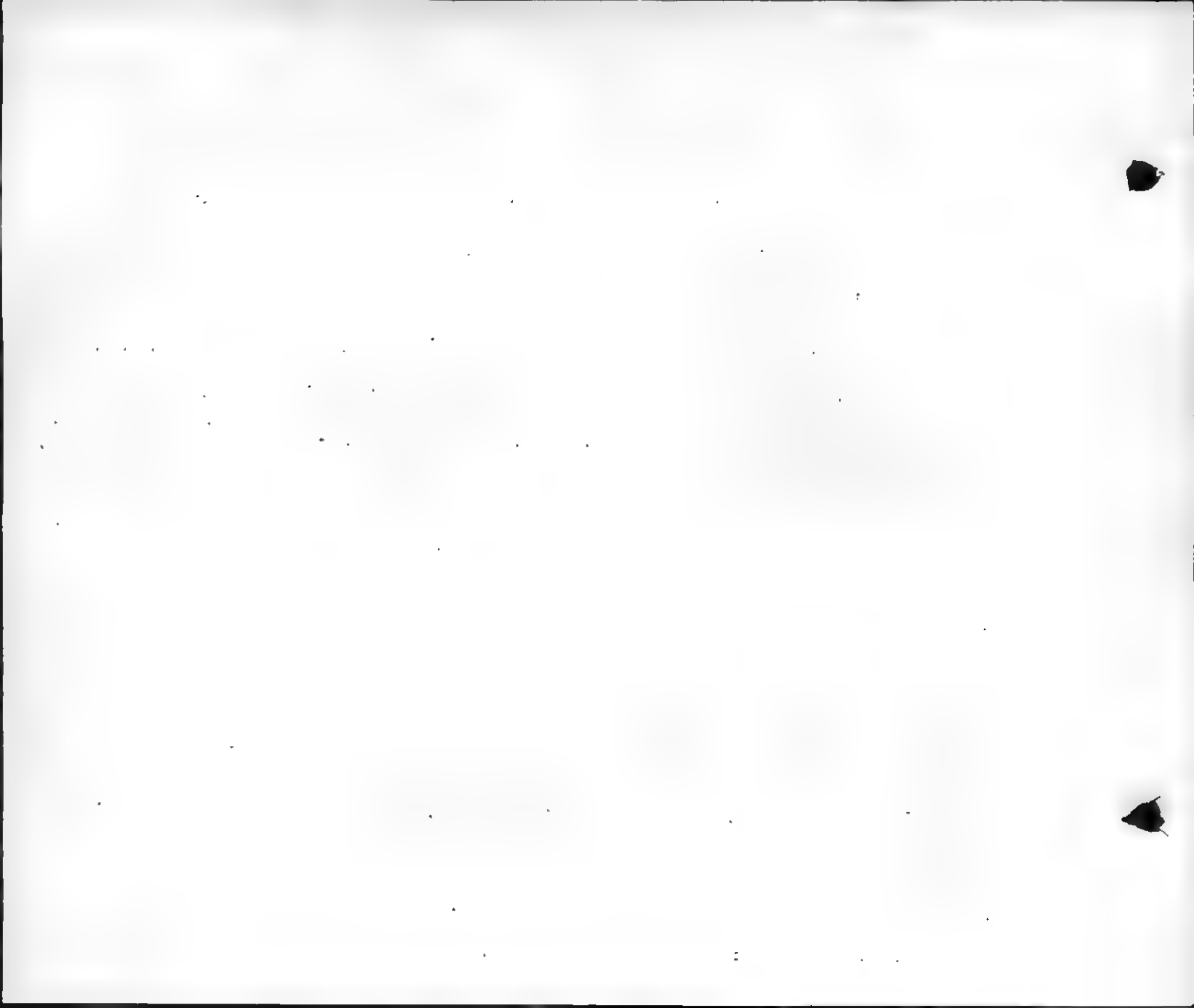
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
04321														
CERTIFICATE OF DEATH														
Reg. Dist. No. 04317														
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON					c. LENGTH OF STAY IN 1b 1 WEEK									
d. NAME OF HOSPITAL (If not in hospital, give street address) ARMACOST NURSING HOME 812 REGESTER					d. STREET ADDRESS 9 South Linwood Avenue									
3. NAME OF HARRY First CLIFTON Middle SHRECK Last					4. DATE OF DEATH APRIL 4 1962									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 5, 1889		9. AGE (In years last birthday) 72 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Retired		10b. KIND OF BUSINESS OR INDUSTRY 15 Years		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME George T. Shreck					14. MOTHER'S MAIDEN NAME Elizabeth Hofferberth									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War #					16. SOCIAL SECURITY NO. 1 6116 A.					INFORMANT 3601 Greenway Apt. 311 Balto. Mr. Milton Shreck 18, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 42 DUE TO Myocardial insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 min 15 mos														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Jan 1961 Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Jan 1961 , to April 3, 1962 , that I last saw the deceased alive on Apr 3, 1962 , and that death occurred at 12:10 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 2900 E Baltimore St DATE SIGNED Charles B. MacArthur														
ACTUAL SIGNATURE Charles B. MacArthur M.D. 2900 E Baltimore St														
PHYSICIAN'S NAME (Type) Charles B. MacArthur														
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 4/7/62		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY			22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND						
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.					24a. REC'D BY REGISTRAR APR 6 '62					24b. REGISTRAR'S SIGNATURE James L. Kline				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04322
CERTIFICATE OF DEATH
04318

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6914 Homeway		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 6914 Homeway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEROY E SHUPE		4. DATE OF DEATH April 7 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-02
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Shupe		14. MOTHER'S MAIDEN NAME Pricilla Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ella Shupe		Address 6914 Homeway, Dundalk 22	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary artery disease 163X DUE TO (b) Interval between onset and death 2 yrs. Conditions, if any, which gave rise to immediate cause (c) underlying DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 5, 1962 to April 7, 1962 What (I) (we) last saw the deceased alive on April 5, 1962 and that death occurred at 11:00 AM from the causes and on the date stated above.			
22a. SIGNATURE S. P. Mackowiak M.D.		22b. DATE SIGNED 4-9-62	
22c. PHYSICIAN'S NAME (Type) S. P. MACKOWIAK		22d. ADDRESS 6714 N. Howard Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Balto. Co., Md	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich		25a. REC'D BY REGISTRAR APR 16 1962	
ADDRESS Funeral Home, Dundalk, Md.		25b. REGISTRAR'S SIGNATURE Arthur J. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

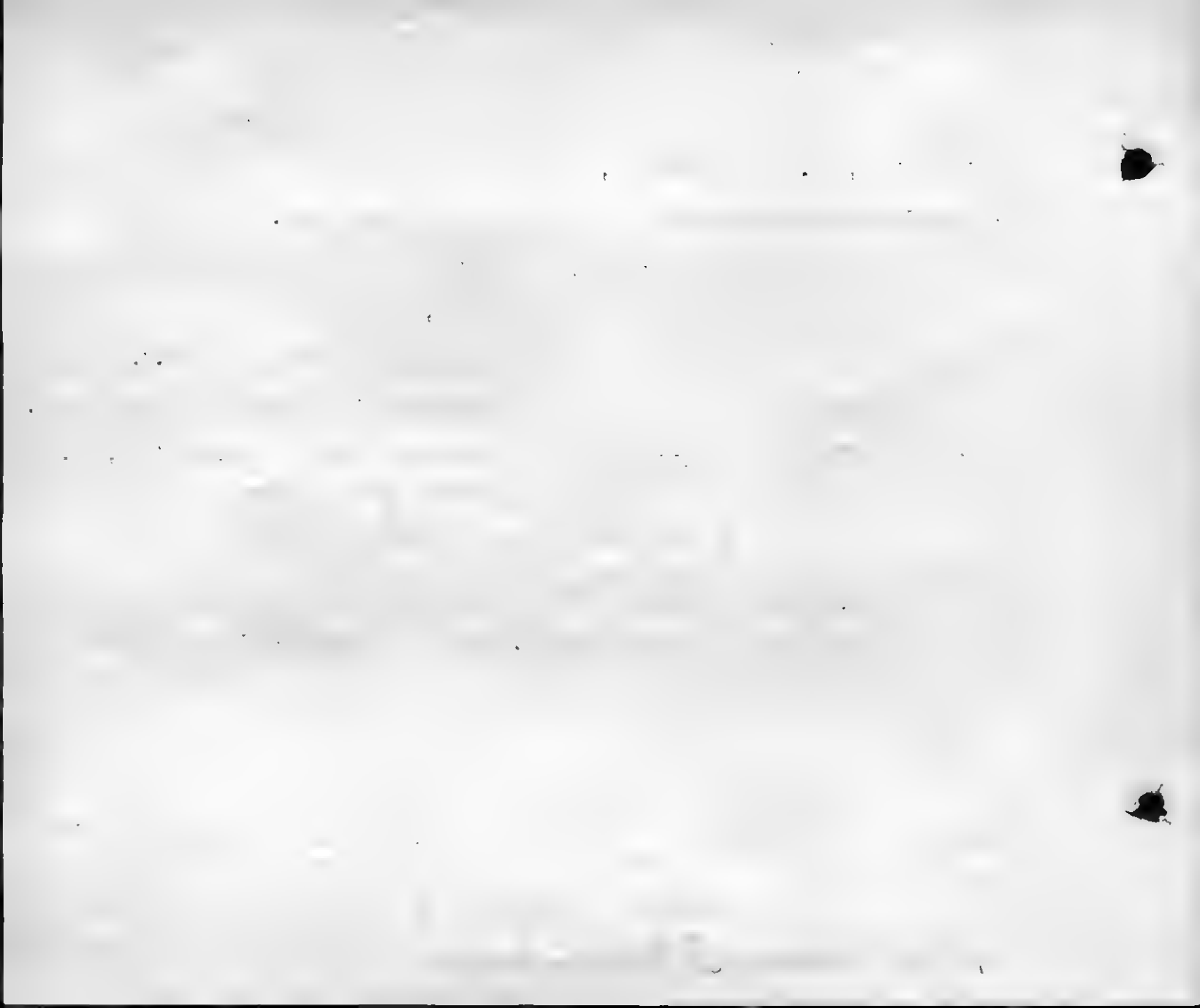
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04319

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled out. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, MD.</u> c. LENGTH OF STAY IN 1b <u>June 25, 1959</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5114 Baltimore Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Dennis James Slunt</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>March 26, 1958</u> 9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges- Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S M.A.DEN NAME <u>Bessie Cecelia Slunt</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Institutional Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>complicating congenital cerebral defect.</u> DUE TO (c) <u>Severe Congenital cerebral defect with microcephaly, convulsive disorder, mental deficiency.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>6-35</u> p.m. <u>55</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6-35-1959</u> 20f. (City or town) <u>Hyattsville</u> (County) <u>Prince Georges</u> (State) <u>Md.</u>		21. I certify that (this hospital) attended the deceased from <u>6-25-1959</u> to <u>4-20-1962</u> that (1) (last) saw the deceased alive on <u>4-20-1962</u> , and that death occurred at <u>6:55</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Edward J. Mathews</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>		22b. DATE SIGNED <u>4-21-62</u> 22d. ADDRESS <u>Rosewood State Tr School</u> <u>Owings Mills, Md.</u>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23c. DATE THEREOF <u>4-24-62</u> 23d. NAME OF CEMETERY OR CREMATORY <u>Southern Methodist</u> 23e. LOCATION (City, town or county) <u>Savage, Maryland</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u> 25. REC'D BY REGISTRAR <u>APR 26 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Thorne</u>	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04324

04320

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>9mth16dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale, Maryland</u> d. STREET ADDRESS <u>5602 - 61st Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>C.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 62</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 20, 1879</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Edward Smith</u> 14. MOTHER'S MAIDEN NAME <u>Mary Tracy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>112-01-2846</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u>19 62</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>June 26, 1961</u> to <u>April 15, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 15, 1962</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslor M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslor, M. D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-16-62</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/18/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> 23d. LOCATION (City, town or county) <u>Washington</u> (State) <u>DC</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Haller's Funeral Home, Inc.</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 72 HOURS AFTER DEATH.

IF THE DECEASED WAS NOT BURIED, CREMATED, OR REMOVED, THE DEATH CERTIFICATE MUST BE FILED WITHIN 72 HOURS AFTER DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04321

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>	
c. LENGTH OF STAY IN <u>Life</u>		d. STREET ADDRESS <u>Cowenton Avenue Box 322</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cowenton Avenue Box 322</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fredrick William Snitker</u>		4. DATE OF DEATH <u>April 9 1962</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 6, 1879</u>	
9. AGE in years last birthday <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Snitker</u>		14. MOTHER'S MAIDEN NAME <u>Annie Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-3625</u>	
17. INFORMANT <u>Mrs Nora Snitker</u>		Address <u>Box 322 Cowenton Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Severe Arterio-sclerotic Cerebral and Cardiovascular</u> (c) <u>6 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Spring, 1958</u> to <u>April, 1962</u> ; that (I) (we) last saw the deceased alive on <u>April 6, 1962</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William H. Tyson</u> M.D.		22b. DATE SIGNED <u>4-9-62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-11-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Michaels Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 10 '62</u>	
ADDRESS <u>7401 Belair Road #6 MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

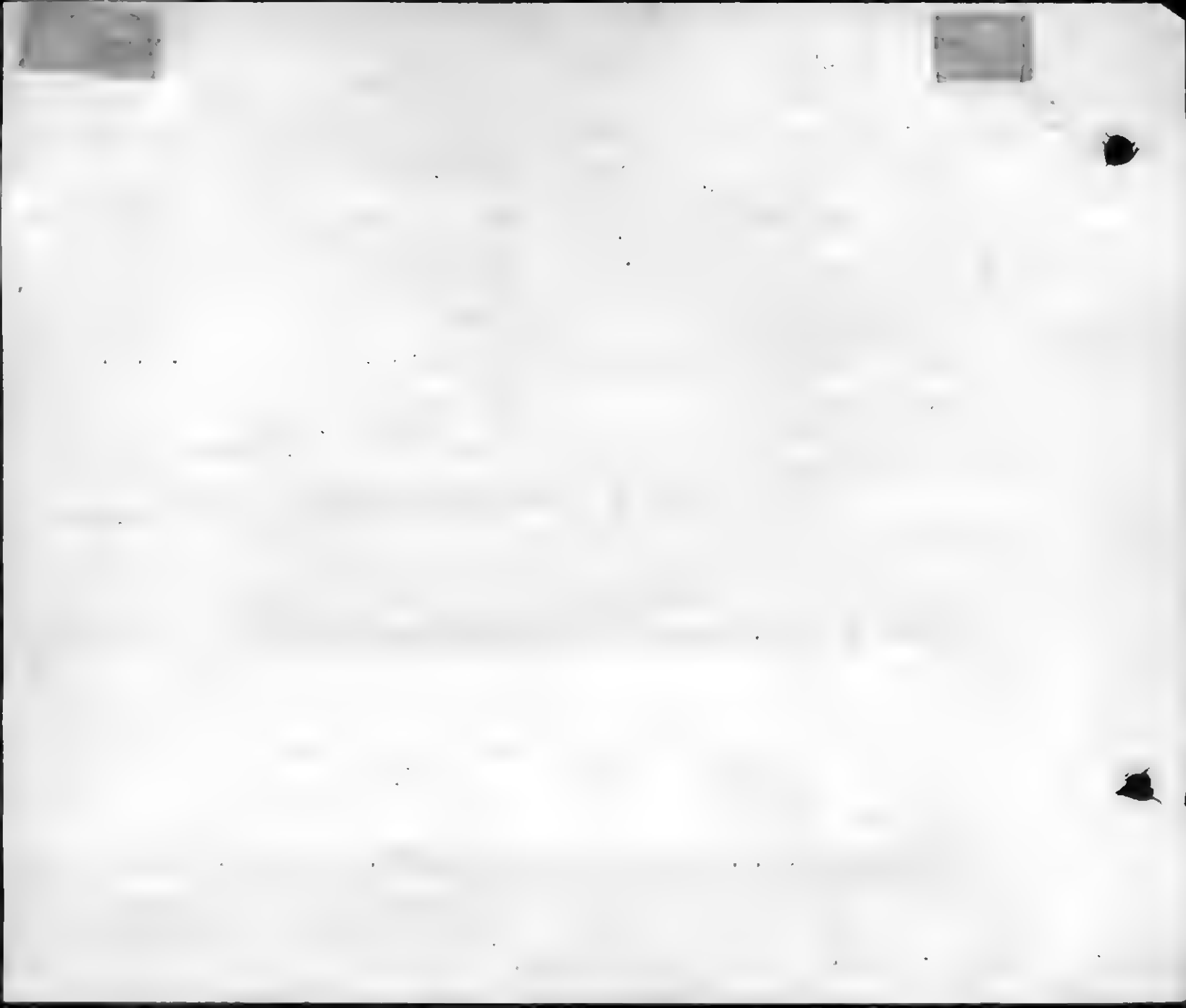


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04326
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 13 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 25 d. STREET ADDRESS 3523 Third Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH C. SOMERVILLE		4. DATE OF DEATH Month Day Year April 3 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 24, 1907	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Food Market	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John C. Somerville		14. MOTHER'S MAIDEN NAME Ella Farrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 215-10-7661	
17. INFORMANT CLINICAL RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS DUE TO GANGRENE OF SMALL BOWEL DUE TO OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (b) 5 (c), stating the underlying cause last. 2 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). PULMONARY EMPHYSEMA. BRONCHOPNEUMONIA, TERMINAL-Duration 2 Days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from March 21 1962, to April 3 1962, that (X) (we) last saw the deceased alive on April 3 1962, and that death occurred at 2:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Sebastian Russo</i>		22b. DATE SIGNED 4/3/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully		25a. REC'D BY REGISTRAR APR 6 '62	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			



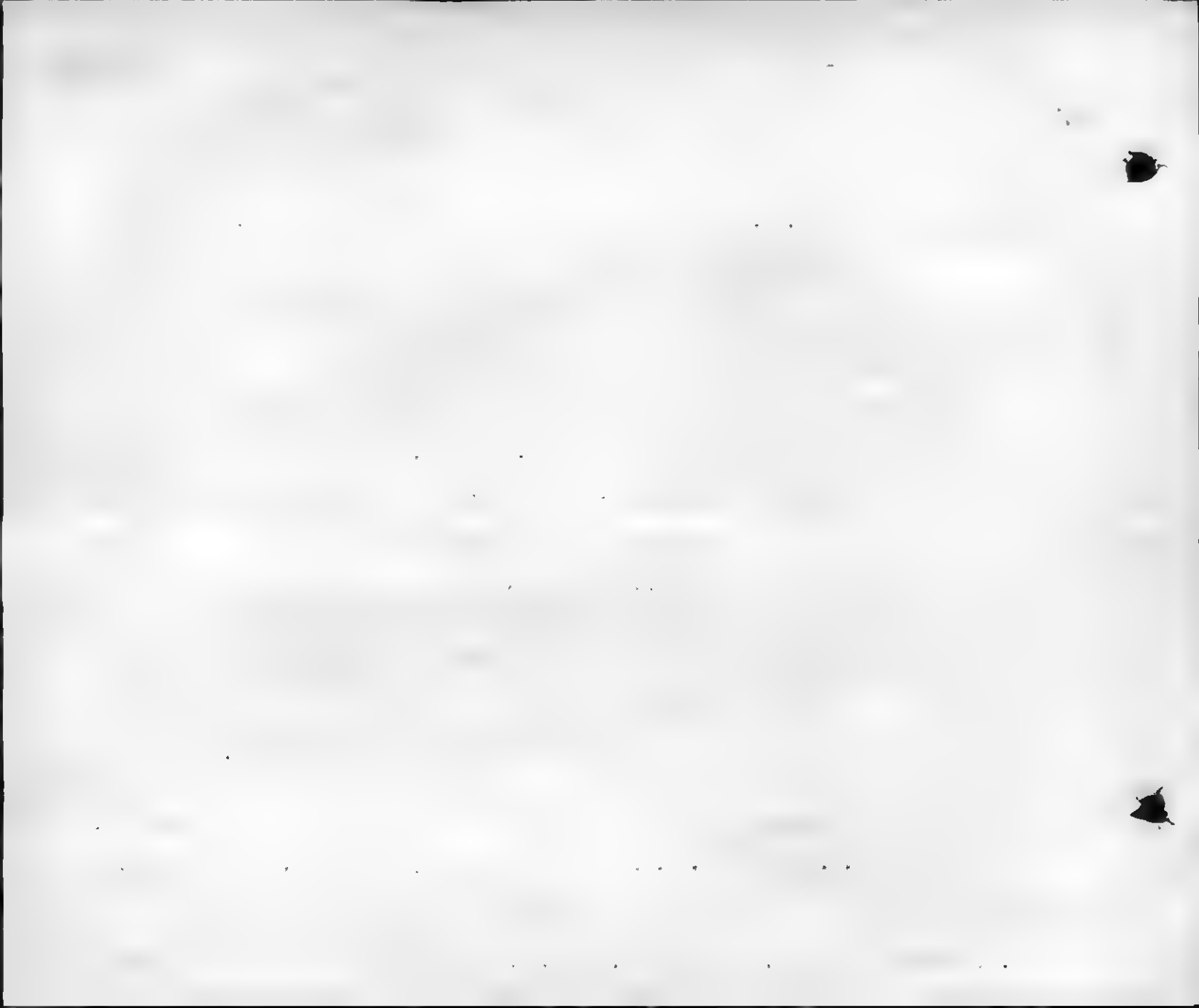
TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04327

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04323

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill N. H.</u>		d. STREET ADDRESS <u>7120 Sheffield Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Hodges</u> Middle <u>Sneake</u> Last		4. DATE OF DEATH <u>April</u> Month <u>2</u> Day <u>1962</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Oden Hodges</u>		14. MOTHER'S MAIDEN NAME <u>Mary N. Claggett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - hypostatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) <u>physician</u> attended the deceased from <u>June 1959</u> to <u>April 2, 1962</u> , that (I) <u>not</u> saw the deceased alive on <u>March 29, 1962</u> , and that death occurred at <u>11 am</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>S. J. Venable, Jr. M.D.</u>		22b. DATE SIGNED <u>April 3, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u>		22d. ADDRESS <u>7215 York Road, Baltimore 12, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-5-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Durham Church</u>	23d. LOCATION (City, town or county) <u>Trionsides</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR <u>APR 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Caroline S. Hanes</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

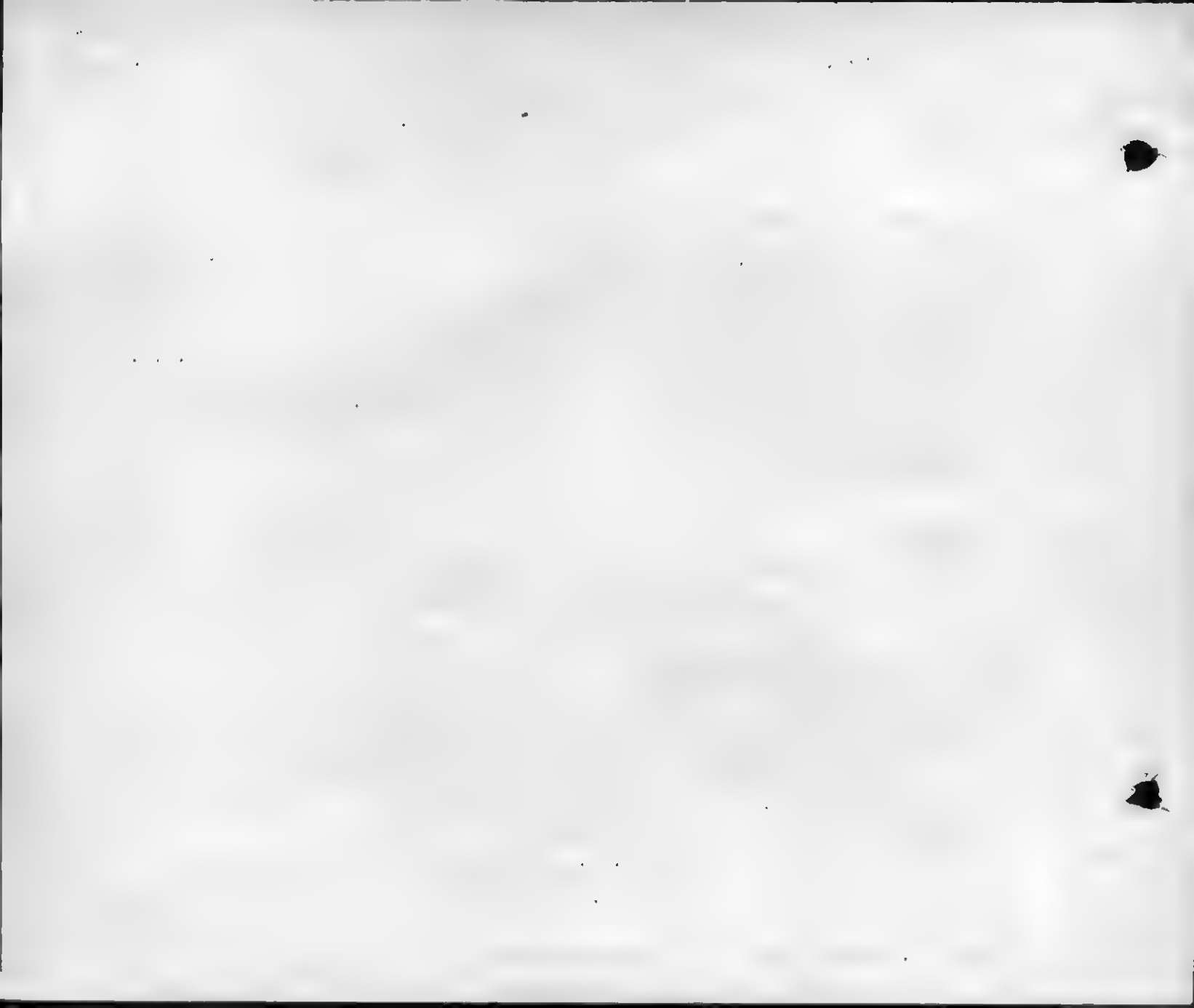
CERTIFICATE OF DEATH

04328

04324

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN it d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Walker Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Catonsville)</u> d. STREET ADDRESS <u>Walker Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice L. Stabler</u>		4. DATE OF DEATH Month Day Year <u>April 15, 19 62</u>	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 20, 1884</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Newman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth J. (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Edmund Stabler 1230 Circle Drive #27</u>	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic interstitial pulmonary</u> (b) <u>Emphysema</u> (c) <u>Chr. valvular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>++ years</u> <u>++ years</u> <u>++ yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 14, 1962</u> 19 <u>30</u> to <u>April 15, 1962</u> that (I) (we) last saw the deceased alive on <u>April 14, 1962</u> and that death occurred at <u>4 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederic Beitler, M. D.</u>		22b. DATE SIGNED <u>APR 18 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederic Beitler, M. D.</u>		22d. ADDRESS <u>1014 Francis Avenue #27</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Stablersville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Stablersville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		25a. REC'D BY REGISTRAR <u>APR 18 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		25c. ADDRESS <u>4107 Wilkens Avenue #29</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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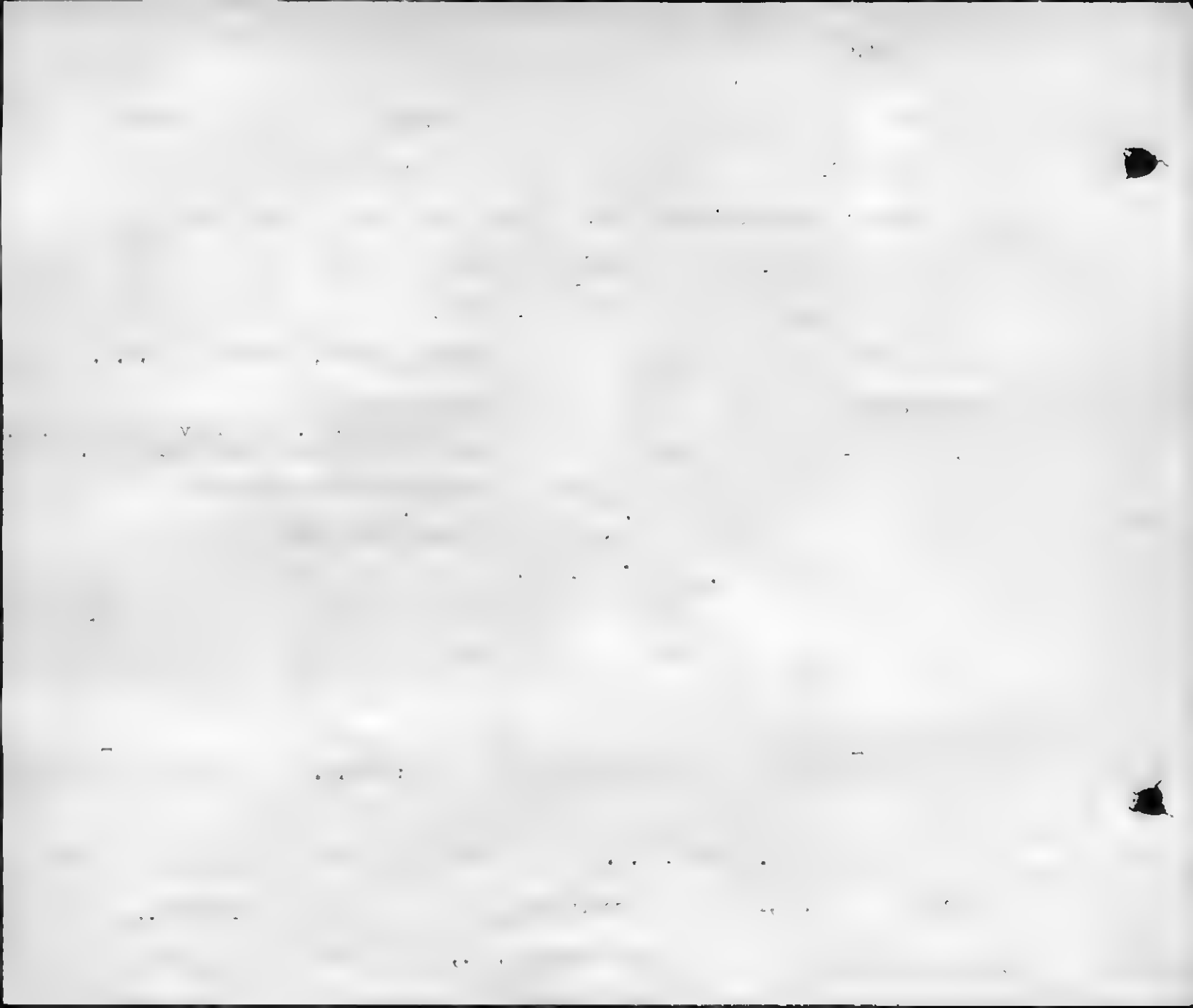
04325

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS Swan Harbor Dell Trailer Park	
3. NAME OF DECEASED (Type or print) Gerald Raymond STARK		4. DATE OF DEATH 4 23 19 62	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTH PLACE (Country & State, or foreign country) Harford County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Jones		14. MOTHER'S MAIDEN NAME Delores Jean Stark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Robert D. Frank, Harford County, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Cardiac failure secondary to coarctation of the aorta and reduplication of mitral valve	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Atonic Deplegia	
21. I certify that (this hospital) attended the deceased from 10/16 to 4/23 , 19 62 , that (we) last saw the deceased alive on 4/23 , 19 62 , and that death occurred at 1:45 a.m. on the date stated above.		22. SIGNATURE Harry G. Butler, M.D.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial Apr. 26 1962		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial	
23d. LOCATION (City, town or county) Abingdon, Harford, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Thomas	
25a. REC'D BY REGISTRAR APR 27 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of 7 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

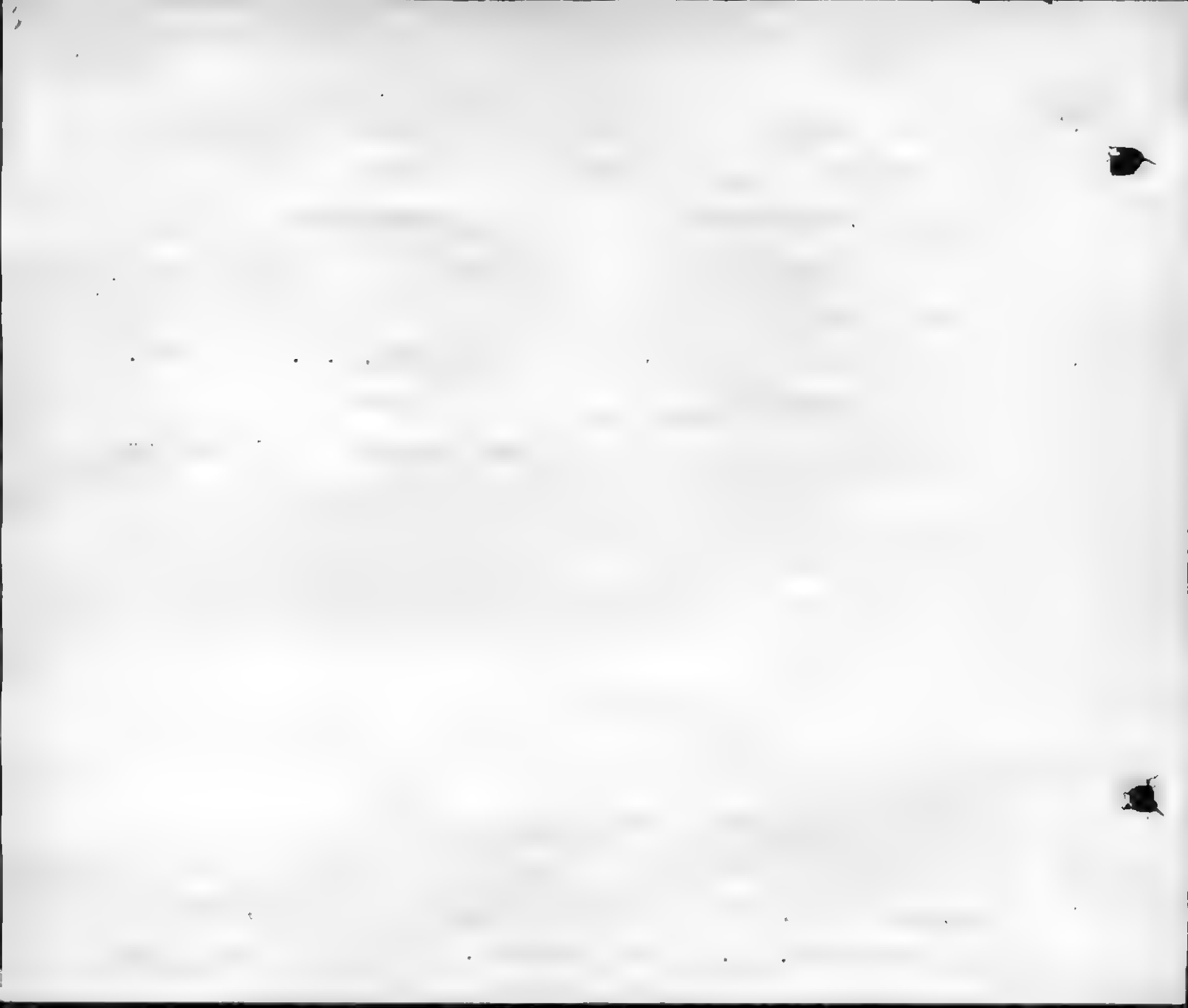
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04330

04326

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN IL <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11 Slade Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>11 Slade Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>				8. DATE OF BIRTH <u>STEINBACH</u> 9. AGE (In years last birthday) <u>64</u> yrs. 10. DATE OF DEATH <u>April 29</u> 19 <u>62</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>Harris Levy</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Samuel Steinbach</u> Address <u>11 Slade Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphoid Leukemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				20c. TIME OF INJURY Month, Day, Year <u> </u> 20d. INJURY OCCURRED <u> </u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>March 28, 1962</u> to <u>April 29, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 28, 1962</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>Louis Kransse</u> 22b. DATE SIGNED <u> </u> 22c. PHYSICIAN'S NAME (Type) <u>Louis Kransse</u> 22d. ADDRESS <u>11 E. Chase St.</u> M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 1, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Congregation</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson & Bros. Inc. 6010 Reisterstown Rd.</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kransse</u> DATE <u>MAY 1 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04331

04327

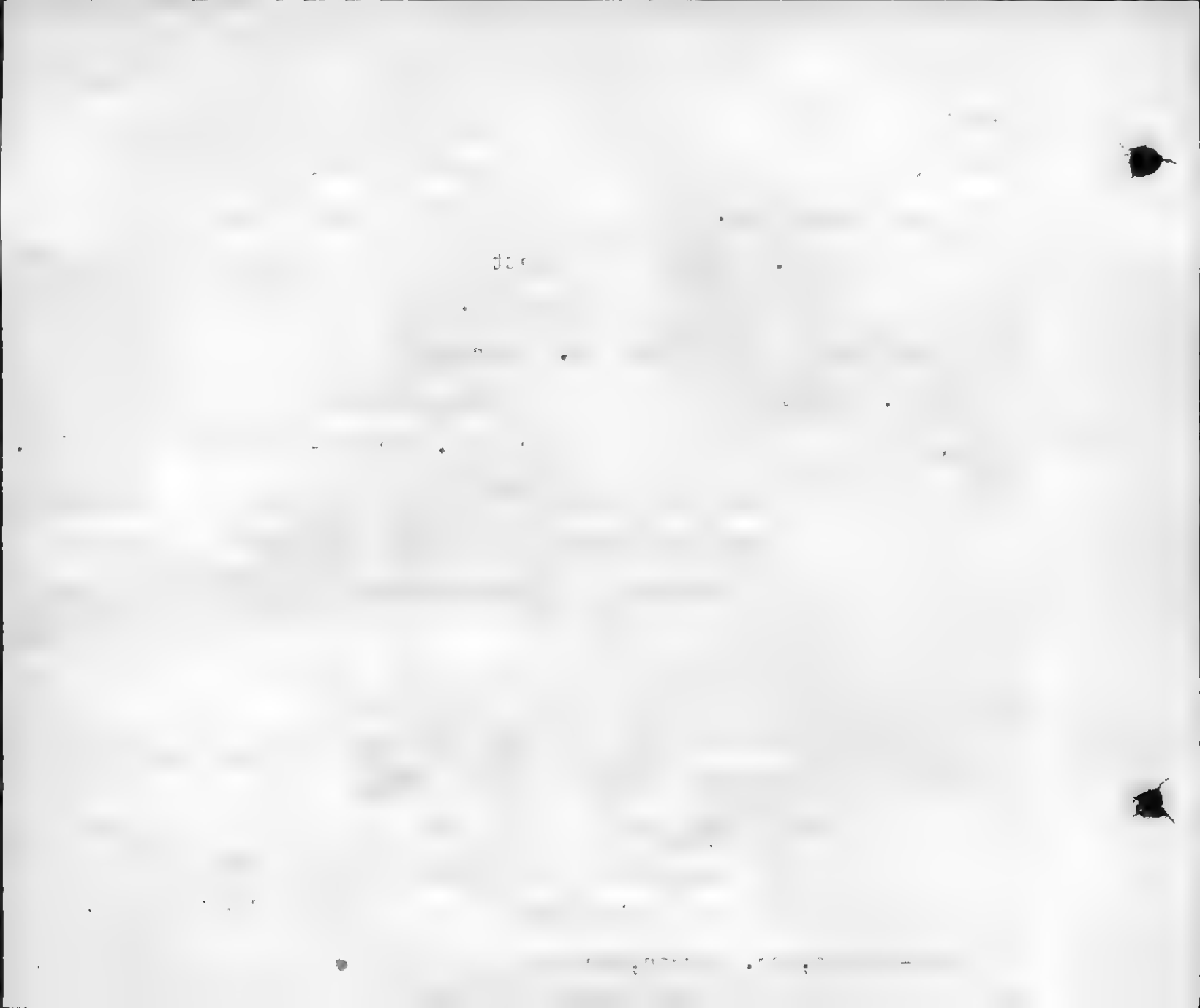
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN MARYLAND Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1234 Vogt Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1234 Vogt Avenue	
3. NAME OF DECEASED (Type or print) Lola B. Stivers		4. DATE OF DEATH April 11, 1962	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1913	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) checker		10b. KIND OF BUSINESS OR INDUSTRY Aetna Shirt Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph I. Widerman		14. MOTHER'S MAIDEN NAME Lola E. Tyson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. George A. Stivers, 1234 Vogt Avenue #27	
17. INFORMANT George A. Stivers, 1234 Vogt Avenue #27		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic fever heart disease 401.5 DUE TO (b) Rheumatic fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to April 11, 1962 , that (I) (we) last saw the deceased alive on April 10, 1962 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE I. Earl Pass M.D.		22b. DATE SIGNED 4-12-62	
22c. PHYSICIAN'S NAME (Type) I. Earl Pass, M. D.		22d. ADDRESS 4001 Wilkens Avenue #29	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/62	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR APR 13 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04332 Item 4FilmG310 4/4/62 JWK											
04328											
1. PLACE OF DEATH											
a. COUNTY Baltimore MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, 4											
c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8302 Loch Raven Blvd. 4											
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. STATE Maryland b. COUNTY Baltimore											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, 4 Md.											
d. STREET ADDRESS 8302 LochRaven Blvd 4											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) T. Armour Streett											
4. DATE OF DEATH April 2 1962											
5. SEX Male											
6. COLOR OR RACE White											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH May 14, 1888											
9. AGE (In years last birthday) 73 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent Building Con.											
11. BIRTHPLACE (County & State, or foreign country) Maryland											
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Abram T. Streett											
14. MOTHER'S MAIDEN NAME Irene Burton											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No											
16. SOCIAL SECURITY NO. Irene D. Streett-8302 Loch Raven Blvd.											
17. INFORMANT Irene D. Streett-8302 Loch Raven Blvd.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis											
Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic Heart Disease											
cause last, (c) Coronary Thrombosis First attack											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 8-4-1958 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4-2-1962 20f. (City or town) Baltimore (County) Maryland (State)											
21. I certify that (I) (this hospital) attended the deceased from 8-4-1958 to 4-2-1962 that (I) (we) last saw the deceased alive on 4-2-1962 and that death occurred at 4:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE Robert A. Silver M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4-2-62											
22c. PHYSICIAN'S NAME (Type) R. H. Silver 22d. ADDRESS 3105 N. Charles St. 18.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/4/62 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge 23d. LOCATION (City, town or county) Baltimore, Maryland (State)											
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. Towson, Maryland ADDRESS Towson, Maryland 25a. REC'D BY REGISTRAR APR 4 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Thane											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State-Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

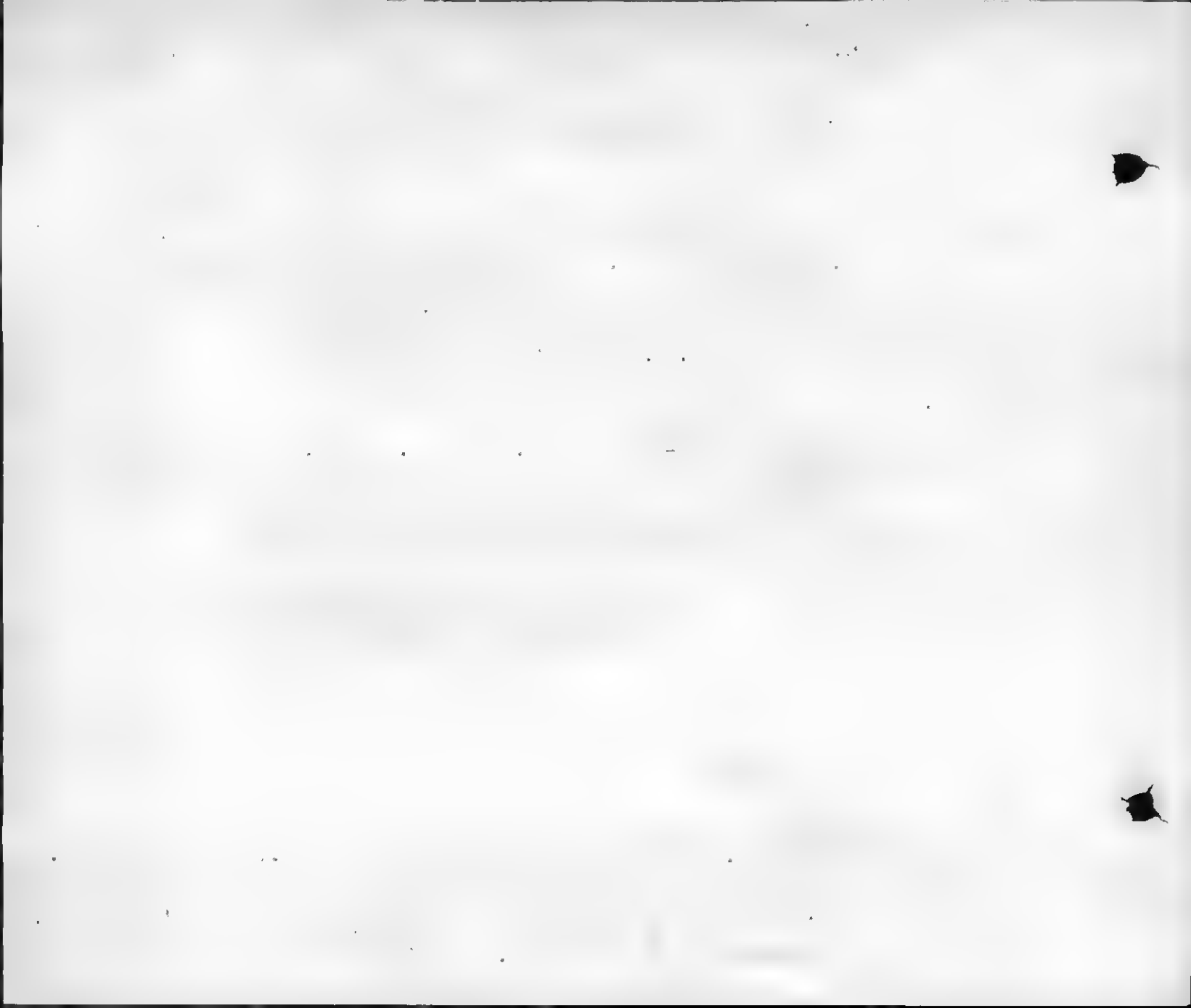
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04334

04330

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Baltimore 7				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Baltimore 7			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6924 Dogwood Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mr. Harry E. Subock		First Middle Last		4. DATE DEATH April 19 19 62		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1899	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Bureau of Utilities			
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Subock				14. MOTHER'S MAIDEN NAME Nettie Reely			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 218-09-4456			
17. INFORMANT Mrs. Bessie R. Subock, Baltimore 7, Maryland				Address 6924 Dogwood Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO VASCULAR Dis. 241X DUE TO Conditions, if any, which gave rise to immediate cause (b) BRONCHIAL ASTHMA (c) 10 yrs. cause last. 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 1946 to APRIL 1962 , that (I) (we) last saw the deceased alive on 4/19/62 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Norman R. Kleiman				22b. DATE SIGNED 4/20/62			
22c. PHYSICIAN'S NAME (Type) Dr. Norman R. Kleiman				22d. ADDRESS 3803 Edmondson Ave., Baltimore 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION (City, town or county) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR DATE APR 23 '62			
25b. REGISTRAR'S SIGNATURE Loring Byers							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

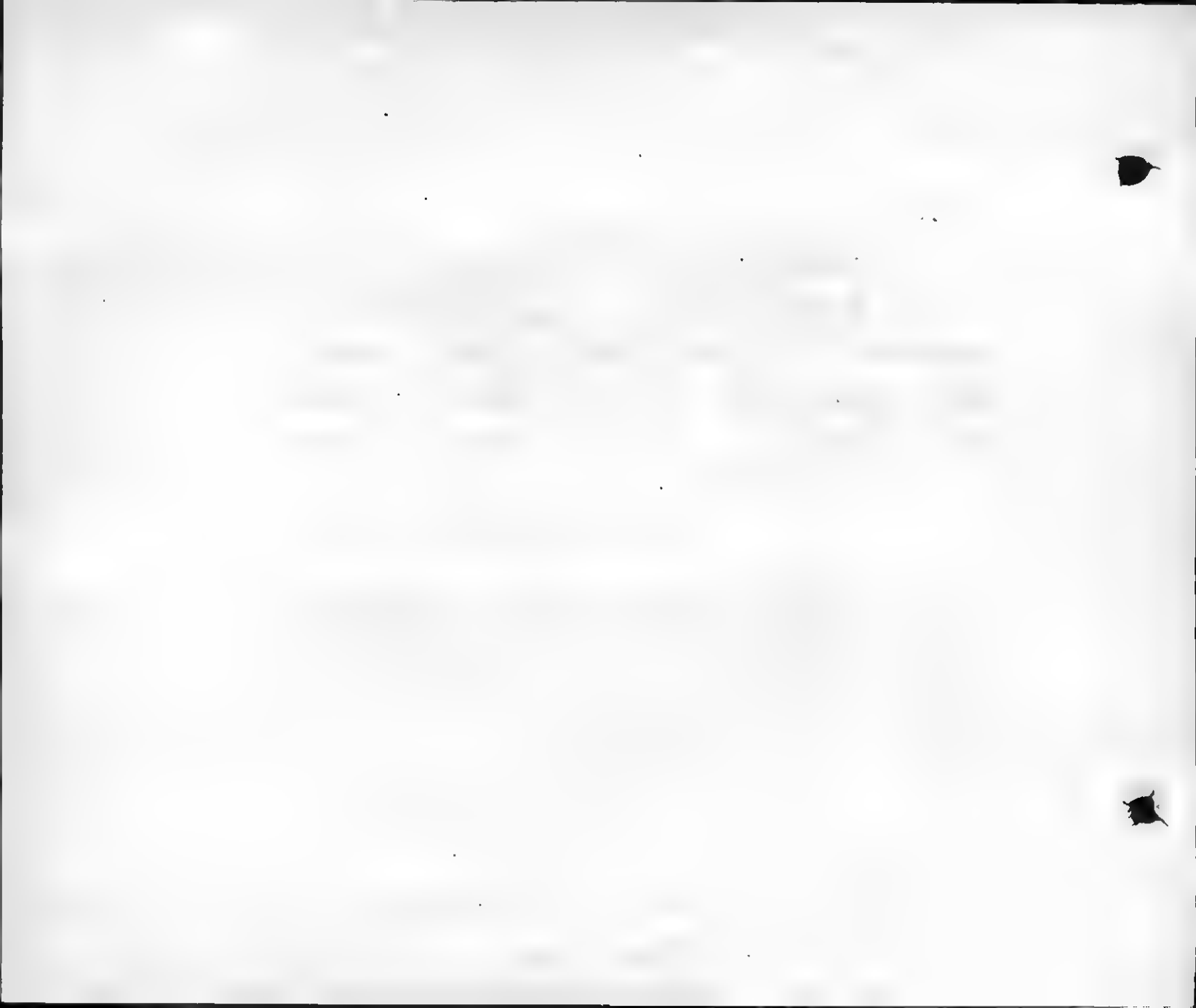
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04335

04331

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb 2 MON.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVALESCENT HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE G. SUCRO		4. DATE OF DEATH Month Day Year APRIL 4 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 22, 1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY GREENLEAF		14. MOTHER'S MAIDEN NAME GERTRUDE POOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. —	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4 4 2 DUE TO Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) HYPERTENSIVE-ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERAL CEREBRAL HEMORRHAGES SINCE OCT 1960		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/10 1962 to 4/4 1962 that (I) (we) last saw the deceased alive on 4/2 1962 and that death occurred 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE T. C. SIWINSKI		22b. DATE SIGNED 4/6/62	
22c. PHYSICIAN'S NAME (Type) T. C. SIWINSKI		22d. ADDRESS 206 W. PENNA. AVE TOWSON 4 MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 7, 1962	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		23d. LOCATION (City, town, or county) (State) PIKEVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR APR 9 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

DP

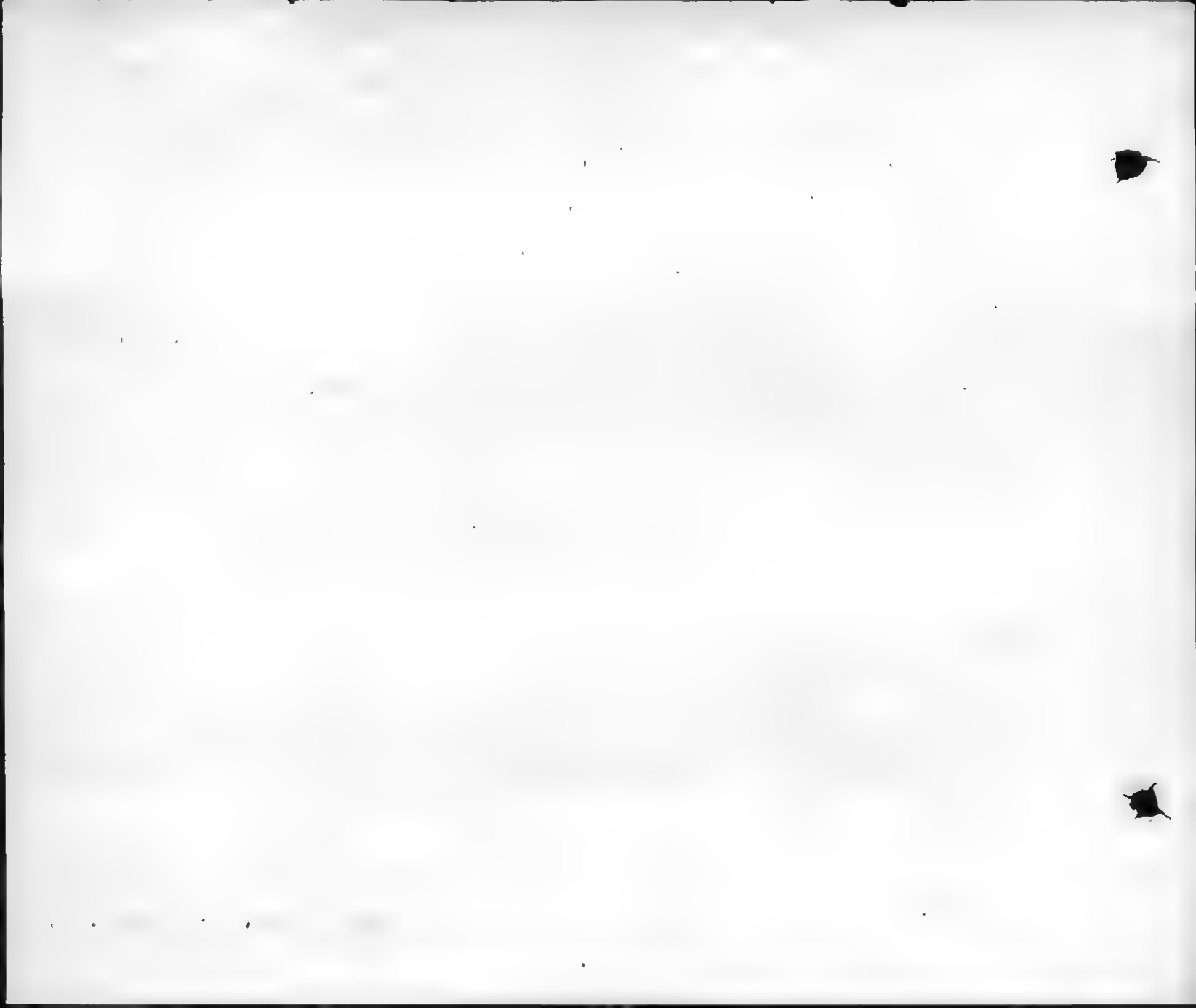


may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04336		Item 8 Film 3311 4/18/62 mh		04332	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN 1b 40 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Slade Ave & Reisterstown Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS Slade & Reisterstown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle TAMBURO Last TAMBURO		4. DATE OF DEATH Month April Day 12 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1864 Sept. 11-1867	9. AGE (In years last birthday) 97 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Stephen Tamburo		14. MOTHER'S MAIDEN NAME Marzula			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT John A. Tamburo Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TERMINAL PNEUMONIA 2. DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ARTERIOSCLEROTIC HEART DISEASE (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-9, 1962 to 4-12, 1962 that (I) (we) last saw the deceased alive on 4-12, 1962 and that death occurred at 11:45P , from the causes and on the date stated above.					
22a. SIGNATURE Samuel P. Scalia		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-1962		23c. NAME OF CEMETERY OR CREMATORY Holy Reedmer	
23d. LOCATION (City, town, or county) (State) Belair Rd. Baltimore, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		ADDRESS Pikesville, Md.		25a. REC'D BY REGISTRAR APR 16 '62	
				25b. REGISTRAR'S SIGNATURE Carlton S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04337

04333

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 27 Days		2. USUAL RESIDENCE (Where deceased lived, if instilled on: Residence before admission) a. STATE Maryland		b. COUNTY -	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1929 McElderry Street		4. DATE OF DEATH Month April Day 3 Year 19 62		9. AGE (In years last birthday) 68 yrs	
3. NAME OF (Type or print) JOHN V. TAUBER		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 7, 1894		11. BIRTH-PLACE (County & State or foreign country) Baltimore, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Furniture Factory		11. BIRTH-PLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Tauber	
14. MOTHER'S MAIDEN NAME Mary Biebl		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-03-7496		17. INFORMANT Clinical Records, VA HOSPITAL, FORT HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PYELONEPHRITIS (c) METASTATIC CARCINOMA, ADRENALS, LYMPH NODES		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS Unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)		20i. (City or town)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 7, 1962 , to April 3, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 3, 1962 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.		22a. SIGNATURE Sebastian Russo		22b. DATE SIGNED 4/3/62		22c. PHYSICIAN'S SEBASTIAN RUSSO, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/62		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION (City, town or county)		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE DIPPEL BROS		24a. ADDRESS 1800 E. LOMBARD ST		24b. REC'D BY REGISTRAR APR 5 '62		24c. REGISTRAR'S SIGNATURE Arthur S. Hume		24d. DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04338

04334

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived, if inst. inst. of Residence before admision) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>x Catonsville</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>935 Coleridge Rd.</u>		d. STREET ADDRESS <u>935 Coleridge Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First <u>Taylor</u> Middle Last		4. DATE OF DEATH <u>April 8</u> 19 <u>62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP. 24, 1877</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State or foreign country) <u>Balto. Md.</u>
13. FATHER'S NAME <u>Oliver Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Annie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>ll 82511-16</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) + 12.1	(b) <u>ARTERIOSEPTOTIC CARDIO-vascular Disease</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.	(c)	SYRST

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
OSTEOARTHRITIS, SEVERE DEFORMITY

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)


MEDICAL	20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town; (County) (State)
	Hour	a.m.		While at work	Not While at work		
			19	<input type="checkbox"/>	<input type="checkbox"/>		

21. I certify that (I) (this hospital) attended the deceased from Jan, 1950 to 4/18, 1962 that (I) (we) last saw the deceased alive on 4/18, 1962 and that death occurred at 11:00 M. from the causes and on the date stated above.

22a. SIGNATURE <i>Blair E. Church</i>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>THOS E. Church</i>		22d. ADDRESS <i>5550 Baitu Natl Pike - 28</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	4/11/62	St. Peters	Balto, Md	

24. FUNERAL DIRECTOR'S SIGNATURE *Wittke F.N. 401 Edmondson* ADDRESS *401 Edmondson* 25a. REC'D BY REGISTRAR *APR 12 '62* 25b. REGISTRAR'S SIGNATURE *Arthur S. Travis*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

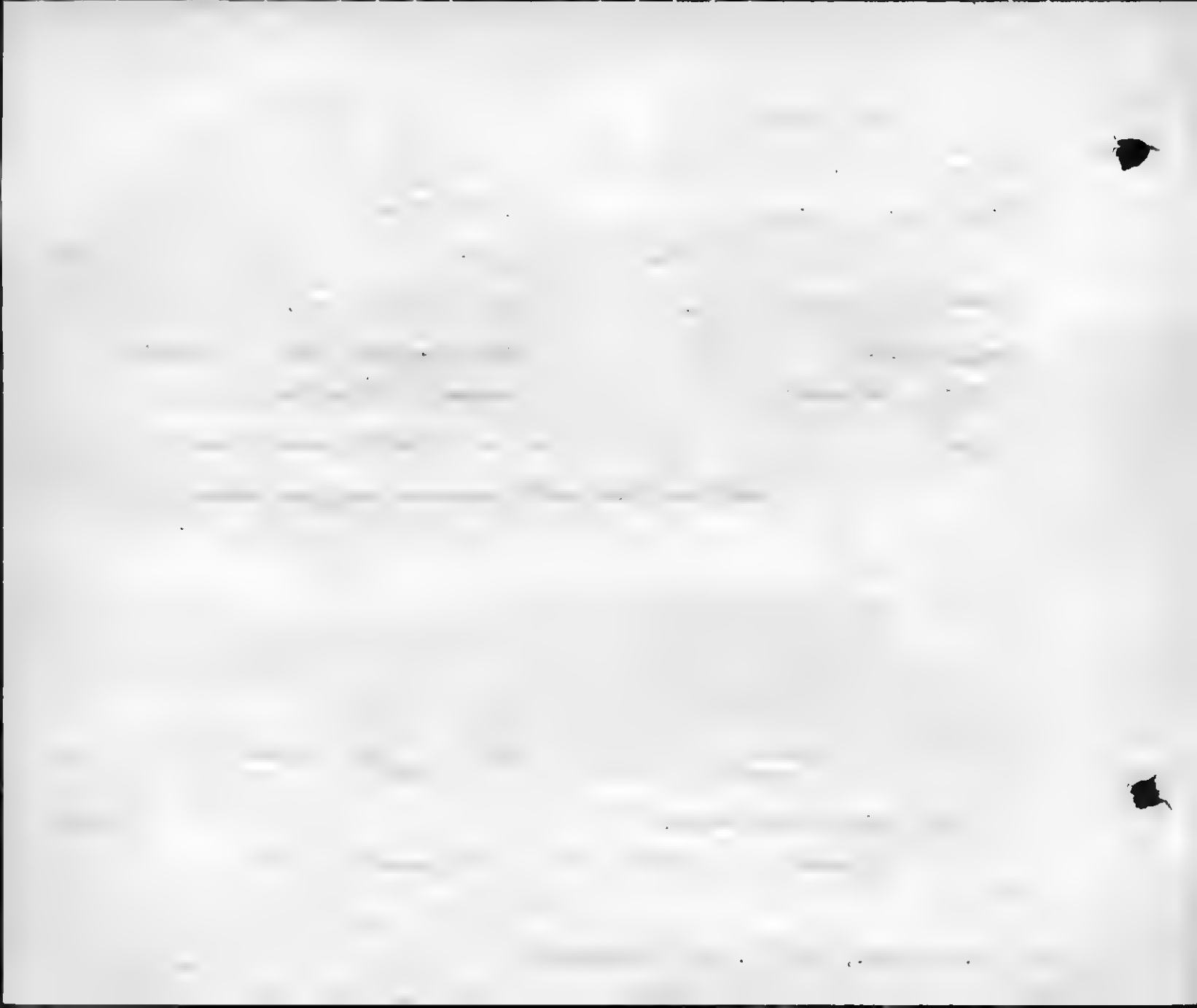
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15M 9/60

04339

04335

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md. Masonic Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ba Ho.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Louise Teackle</u>		d. STREET ADDRESS <u>1123 Eutaw St.</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1874</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS.: Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto Duker</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. Radica</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Masonic Home Records - Cockeysville</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebrovascular disease</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 14</u> to <u>April 17</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 14</u> , 19 <u>62</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Sherrill</u>		22b. DATE SIGNED <u>4/17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>		22d. ADDRESS <u>Cockeysville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-19-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</u>		25a. REC'D BY REGISTRAR <u>APR 19 62</u>	
25b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Sherrill</u>		25c. DATE <u>APR 19 62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04340

04336

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 W. Pennsylvania Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOHN Middle ANDREW Last THORWORTH		4. DATE OF DEATH Month April Day 1 Year 1962	
5 SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 6, 1884	
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor- Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Thoworth		14. MOTHER'S MAIDEN NAME Fronie ? Thoworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION 4 - c - 1 DUE TO GENERALIZED ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 2/15 to 4/1/62 , that (I) (the) last saw the deceased alive on 3/30 1962 and that death occurred at 7:00 M, from the causes and on the date stated above			
22a. SIGNATURE T. C. Siwinski		22b. DATE SIGNED 4/1/62	
22c. PHYSICIAN'S NAME (Type) T. C. SIWINSKI		22d. ADDRESS 206 W. PENNA. AV. TOWSON 4 MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal/Burial		23b. DATE THEREOF April 2, 1962	
23c. NAME OF CEMETERY OR CREMATORY Crest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Clifton, N.J.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		25a. REC'D BY REGISTRAR DATE APR 5 1962	
ADDRESS Towson, Maryland		25b. REGISTRAR'S SIGNATURE	



1
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04341 CERTIFICATE OF DEATH 04337											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeysville</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Maryland Masonic Home</u>				d. STREET ADDRESS <u>4300 Roland Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary E Tingle</u>				4. DATE OF DEATH <u>April 7 1962</u>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Samuel Moore</u>				14. MOTHER'S MAIDEN NAME <u>Mary B. Sommer</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>-</u>				17. INFORMANT <u>Masonic Home Records - Cockeysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 420 DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1961</u> to <u>April 1 1962</u> , that (I) (we) last saw the deceased alive on <u>April 6 1962</u> , and that death occurred at <u>1:30 P</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Elizabeth Sherrill</u> M.D.				22b. DATE SIGNED _____							
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>				22d. ADDRESS <u>Cockeysville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>				25a. REC'D BY REGISTRAR <u>Arthur D. Tolson</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur D. Tolson</u>			
DATE <u>APR 10 '62</u>											



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

24342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04338

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>407 N. RIVERSIDE RD.</u>				d. STREET ADDRESS <u>407 N. RIVERSIDE RD.</u>			
3. NAME OF DECEASED (Type or print) <u>COVA</u> <u>Susan</u>		Frsi Middle Last		4. DATE OF DEATH <u>4 22 19 62</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 24 - 1874</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOSEPH FRIDINGER</u>				14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>				16. SOCIAL SECURITY NO <u>NONE</u>			
17. INFORMANT <u>MRS. NELLIE UNFRIED.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>TYPE 443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>TYPE 443X</u> (b) <u>TYPE 443X</u> (c) <u>TYPE 443X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ABOVE</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 1</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>JACK E. COLLINS</u>				DATE SIGNED <u>4-22-62</u>			
EXAMINER'S NAME (Type) <u>JACK E. COLLINS</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4-25-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT U. B.</u>				22d. LOCATION (City, town, or country) (State) <u>GREENMOUNT CARROLL CO. MD.</u>			
23. FUNERAL DIRECTOR <u>John G. Connelly</u>				24a. REC'D BY REGISTRAR <u>418 Eastern Blvd.</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>				DATE <u>APR 24 '62</u>			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

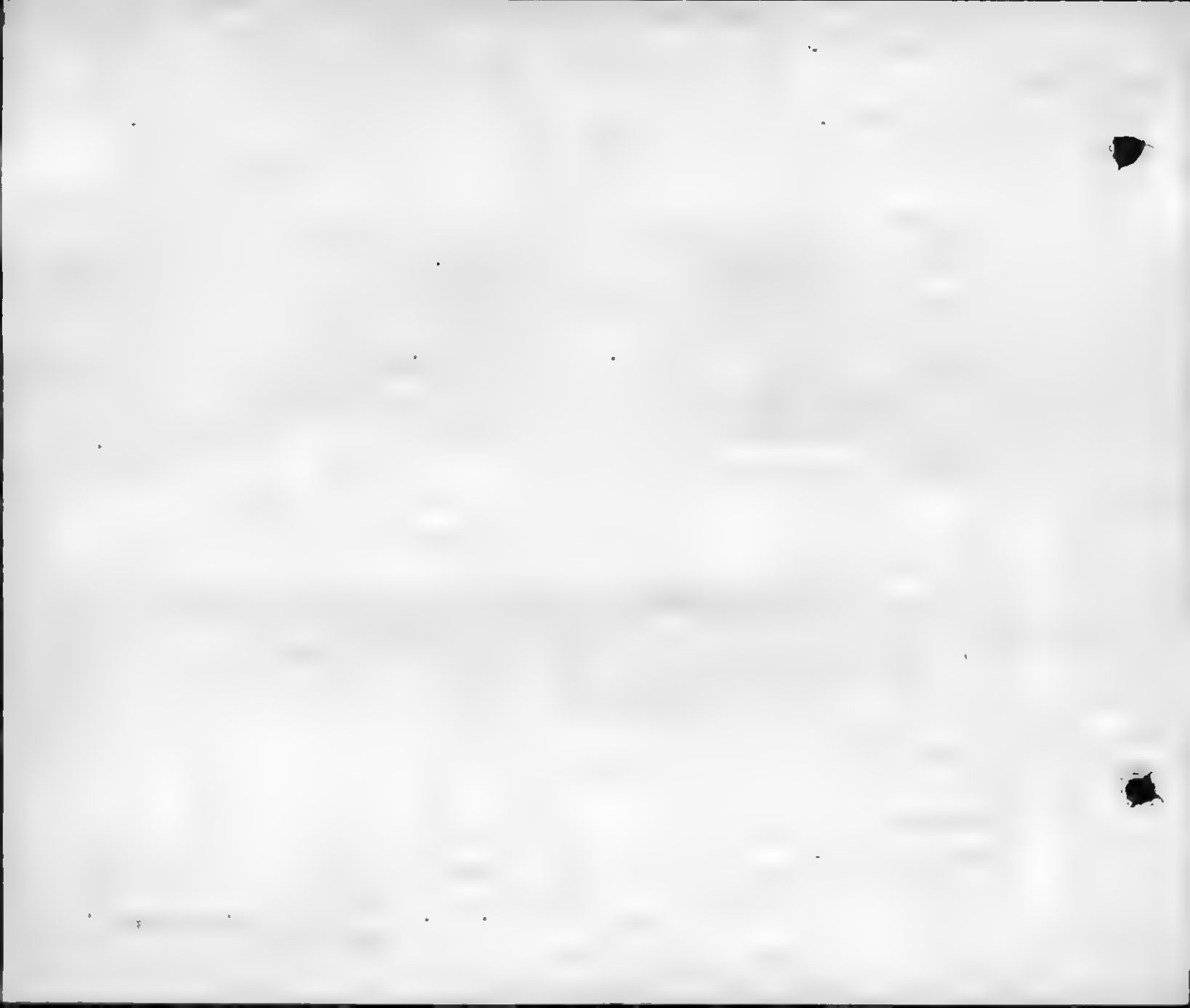
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
043343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 043339

1. PLACE OF DEATH a. COUNTY Balto. Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradshaw Md				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bradshaw Md				e. STREET ADDRESS Bradshaw Md			
3. NAME OF DECEASED (Type or print) John H Ulrich Jr.				4. DATE OF DEATH 4 15 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10-5-1913	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Expiditer				10b. KIND OF BUSINESS OR INDUSTRY Martin Co.			
11. BIRTHPLACE (State or foreign country) Balto. Md				12. CITIZEN OF WHAT COUNTRY U S A			
13. FATHER'S NAME John H Ulrich				14. MOTHER'S MAIDEN NAME Louisa Breback			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 10				16. SOCIAL SECURITY NO. 217-14-2939			
17. INFORMANT Mrs Edna E Ulrich				Address Bradshaw Md.			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stungulation & cervical dislocation due to hanging. 7-1-62 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year: 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John C. Hyle				DATE SIGNED 4-16-62			
EXAMINER'S NAME (Type) JOHN C. Hyle				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-9-1962			
22c. NAME OF CEMETERY OR CREMATORY St Michael's Luth. Cem.				22d. LOCATION (City, town, or country) Baltimore Co. Md.			
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				24a. REC'D BY REGISTRAR APR 17 1962			
				24b. REG. TRANS. SIGNATURE			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04344

04310

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7809 Chelsea St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> h. STREET ADDRESS <u>7809 Chelsea St.</u>			
3. NAME OF DECEASED (Type or print) <u>Peter</u> First <u>Granger</u> Middle <u>Vander Pool</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustas Vander Pool</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Granger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mrs. W. Wilson White</u>				Address <u>Above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio Vascular Disease</u> (c), stating the underlying cause last. <u>Carcinomatosis extensive</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>Carcinoma Prostrate</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year <u>19</u>							
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20d. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1947</u> to <u>4-23-1962</u> that (I) (we) last saw the deceased alive on <u>4-22-1962</u> and that death occurred as <u>1.0M</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>4-23-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>B.H. Rutledge, M.D.</u>							
22d. ADDRESS <u>18 E. Eager St., Baltimore 2, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>							
23b. DATE THEREOF <u>4-25-62</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>							
23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. balto. 12, Md.</u>							
25a. REC'D BY REGISTRAR <u>APR 26 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

M

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MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04345

04341

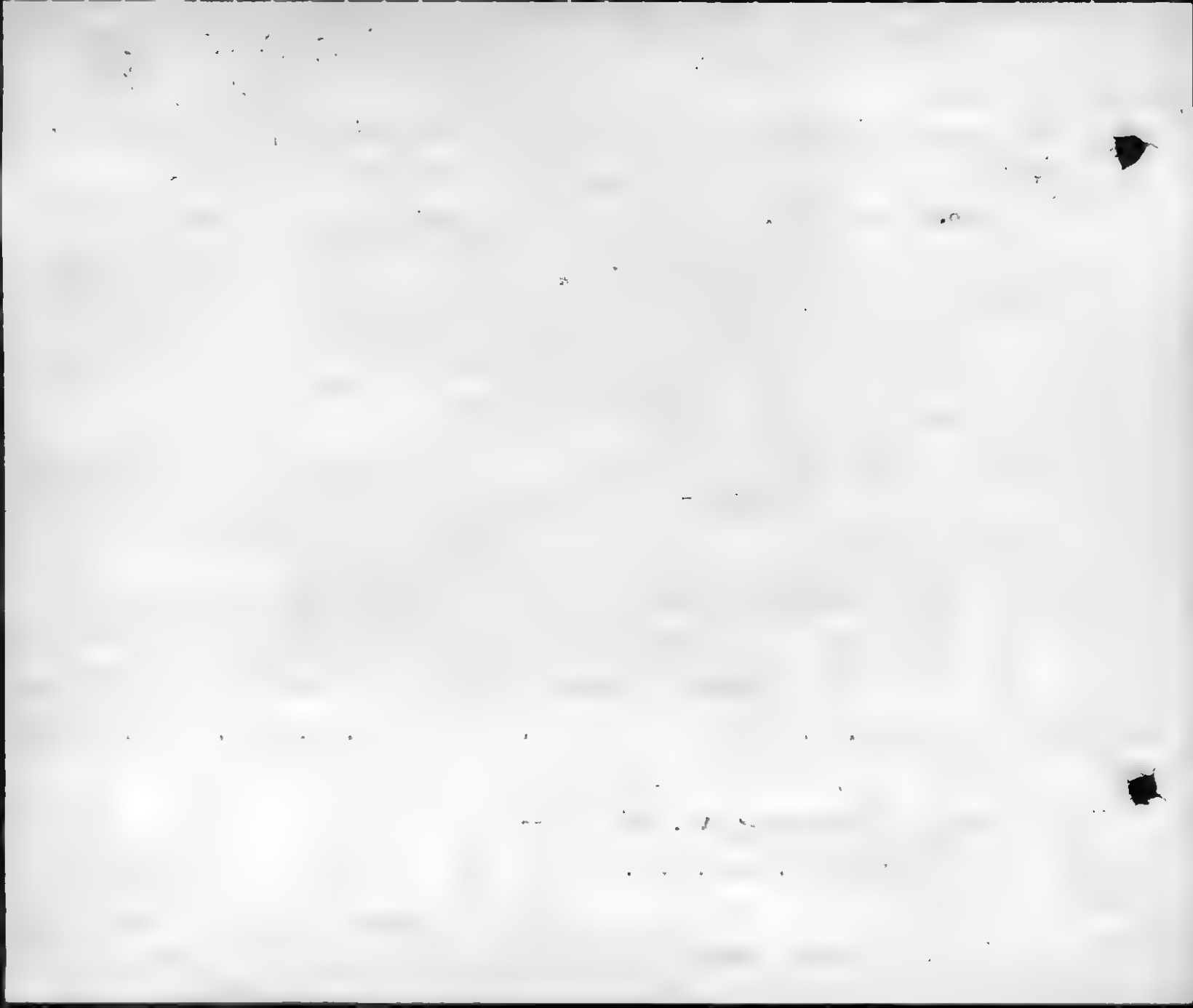
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> d. STREET ADDRESS <u>1808 Sutton Ave.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>				c. LENGTH OF STAY IN b. <u>61 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1808 Sutton Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary B. Vernetson</u>				4. DATE OF DEATH <u>April 22</u> 19 <u>62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>One Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Margaret L. McMahon</u> Address <u>1808 Sutton Ave.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Acute Coronary occlusion 2 hrs</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chr. Cardio Vascular disease 2 yrs</u> (c) <u>Sanility & Hypertension 10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Apr 22 1962</u> that (I) (we) last saw the deceased alive on <u>Apr 20 1962</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Brumbaugh</u> M.D.				22b. DATE SIGNED <u>4/23/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. B. Brumbaugh M.D.</u>				22d. ADDRESS <u>5609 Main St, Elkridge 27, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/26/62</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Maryland.</u>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc. 1328 Sulphur Spring Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			



04346
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04342

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Balto. Beltway at Rt. 40		1135 Riverside Avenue	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
JOHN G. VINSON		April 30, 19 62	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-15-44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
None		School Bus	17 yrs.
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Edwin N. Sr.		Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME	
NO		Catherine Funk	
16. SOCIAL SECURITY NO.		17. INFORMANT	
		Family	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral injury</u>		Same	
819 X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		Passenger in auto which ran through barricade at end of beltway	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Apr. 30, 19 62		Balto. Beltway at Rt. 40, Balto. County, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
HOWARD G. SHAUB, M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
B	5-4-62	22c. NAME OF CEMETERY OR CREMATORY	
		New Cath Cem	
23. FUNERAL DIRECTOR		22d. LOCATION (City, town, or country)	
Mc Gully Funeral Home		Balto. Md.	
ADDRESS		24a. REC'D BY REGISTRAR	
130 E First Ave		DATE MAY 2 '62	
		24b. REGISTRAR'S SIGNATURE	
		William S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04347

04343

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY N 1b 4mth8dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 772 Canal Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence Wagner		4. DATE OF DEATH April 22 19 62		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 27, 1893 9. AGE (in years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Penna. 12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO (b) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with psychosis due to arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from Dec. 9, 1961, to April 22, 1962, that (we) last saw the deceased alive on April 22, 1962, and that death occurred at a.m. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5-1-62		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) buried		23b. DATE THEREOF May 7, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.			
23d. LOCATION (City, town or county) Baltimore, Md.		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE McNabb --- Catonsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 3 '62		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04348

04344

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY B. H. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore 34 d. STREET ADDRESS 3332 Willoughby Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY A. WALLIS		4. DATE OF DEATH April 2 2 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 28, 1883 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days Hours M.n. 11. BIRTHPLACE (County & State, or foreign country) Wharton, Maryland (Worton) 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Samuel W. Wallis		14. MOTHER'S MAIDEN NAME Mary Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-32-9790	
17. INFORMANT Clinical Records VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO MYOCARDIAL HEART FAILURE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from March 27, 1962 , to April 2, 1962 , that (X) (we) last saw the deceased alive on April 2, 1962 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, Acting Chief, Service		22b. DATE SIGNED 4/2/62 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VA Hospital, Fort Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/62	
23c. NAME OF CEMETERY OR CREMATORY I U Cemetery		23d. LOCATION (City, town or county) (State) Kent County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Willis Wells, Chestertown, Maryland		25. REC'D BY REGISTRAR Willis Wells DATE APR 5 '62	
25b. REGISTRAR'S SIGNATURE Christina S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04349

Item 14 Film G312-57762 ind

04345

1. PLACE OF DEATH

a. COUNTY

Baltimore County

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Mt. Wilson

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Md

b. COUNTY

Frederick

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Knoxville

d. STREET ADDRESS

Ind

9. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

(Type or print)

Russell

Charles

Watts

4

29

1962

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

12/16/03

9. AGE (in years last birthday)

58 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Track Hand

10b. KIND OF BUSINESS OR INDUSTRY

B & O, R.R.

11. BIRTHPLACE (County & State, or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Watts

14. MOTHER'S MAIDEN NAME

ELLA WAUGH

Ella Waugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-09-7209

17. INFORMANT

Medical records, Mt. Wilson State Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

16 mo.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Pulmonary Emphysema

6 mo.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3/13 1962 to 4/29, 1962 that (I) (we) last saw the deceased alive on 4/29 1962 and that death occurred at 8 A.M. from the causes and on the date stated above

22a. SIGNATURE

Wm. Newcomer

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

4/29/62

22c. PHYSICIAN'S NAME (Type)

Wm. Newcomer, M.D., Superintendent Mt. Wilson, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 2, 1962

23c. NAME OF CEMETERY OR CREMATORY

Knoxville Cemetery

23d. LOCATION (City, town or county)

Knoxville Ind.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Leila Fennell Home

ADDRESS

Brunswick Md

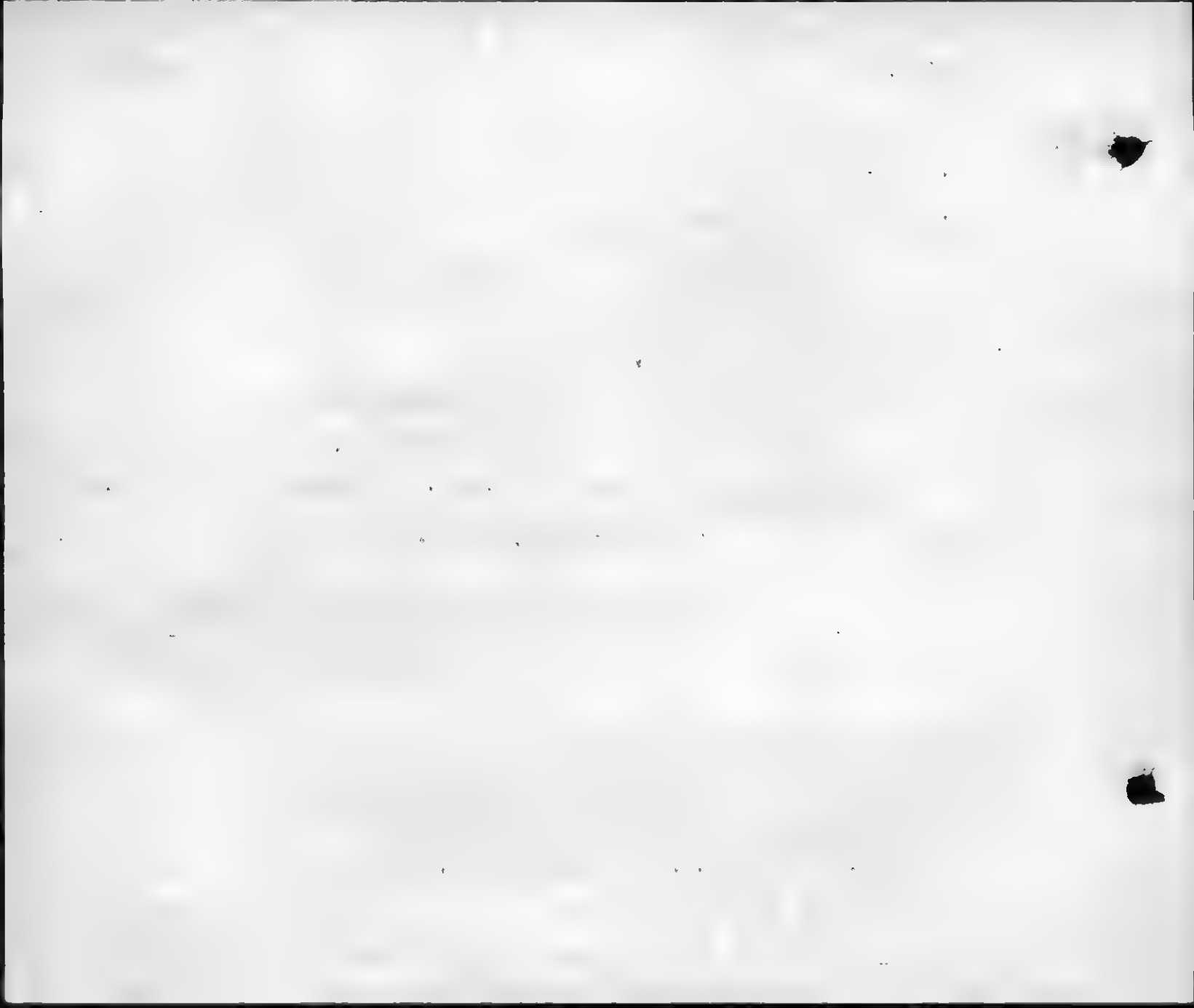
25a. REC'D BY REGISTRAR

MAY 2 '62

25b. REGISTRAR'S SIGNATURE

Clifton S. Kline

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

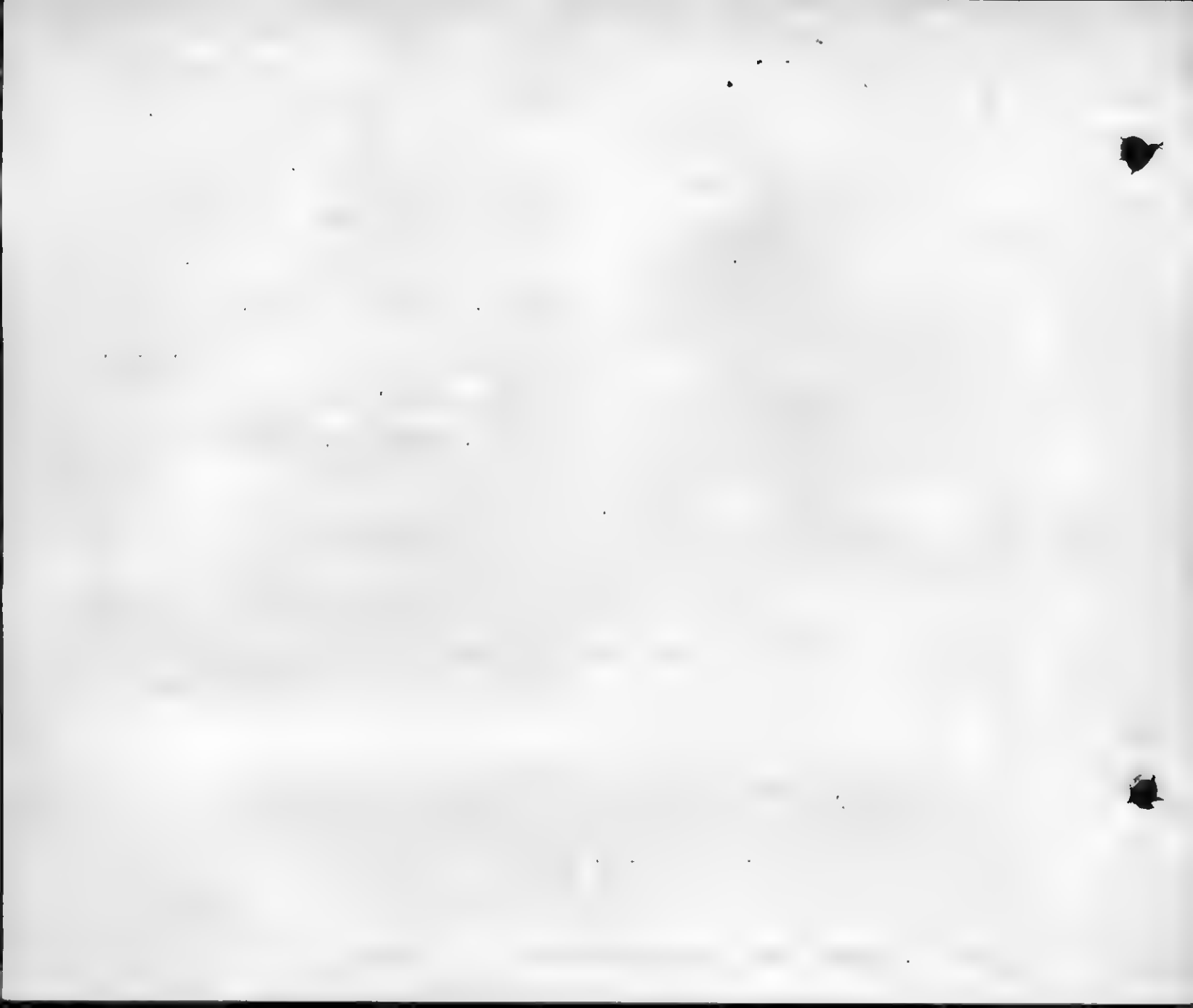
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04350		04346	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1300 North Avenue		d. STREET ADDRESS 1300 North Avenue	
3. NAME OF DECEASED (Type or print) First Flora C. Middle Warren Last Warren		4. DATE OF DEATH Month April Day 21 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 10 Days mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herman R. Pohlhaus		14. MOTHER'S MAIDEN NAME Elizabeth Terveer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Walter T. Warren, Sr., 1300 North Ave. #27		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (b) Arteriosclerotic C.D. Disease (c) Interval between onset and death 10 mm. 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 11-3 p.m. 1959	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4-24	
20f. (City or town) Baltimore		20g. (County) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 11-3, 1959, to 4-24, 1962, that (I) (we) last saw the deceased alive on 12-3, 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John F. Schaefer, M. D.		22b. DATE SIGNED 4-23-62	
22c. PHYSICIAN'S NAME (Type) John F. Schaefer, M. D.		22d. ADDRESS 401 Random Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR DATE 4-24-62	
25b. REGISTRAR'S SIGNATURE William L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04347**

1. NAME OF DECEASED a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HEREFORD RD - RFD-2</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u> d. STREET ADDRESS <u>HEREFORD RD - RFD-2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR P. WATSON</u> First Middle Last				4. DATE OF DEATH <u>APR 7 1962</u> Month Day Year					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 29, 1903</u>			
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>WILLIAM R. WATSON</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE E. FOGELSON</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-14-3855</u>		17. INFORMANT <u>MARGARET L. WATSON - HEREFORD RD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>R. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>R. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/7/62</u>					
22a. BURIAL, CREMATION, or other disposal <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL-7/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEM. GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>FINKSBURG - MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Townson, INC</u>				ADDRESS <u>TOWNSON, MD</u>					
24a. REC'D BY REGISTRAR <u>DATE APR 6 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Wm S. Kline</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 21 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04352

04348

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea c. LENGTH OF STAY IN It 5 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4304 Kenwood Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea d. STREET ADDRESS 4304 Kenwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH K. WEIKERT		4. DATE OF DEATH April 30, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1881
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Hartline		14. MOTHER'S MAIDEN NAME Mary Deigert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Frederick L. Hartline 4304 Kenwood Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Cardio Vascular Disease 422.1 DUE TO Severe Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO under. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition - secondary to bowel discomfort & pain			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19, to April 30, 1962 , that (I) (we) last saw the deceased alive on April 28, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John C. Hyle M.D.		22b. DATE SIGNED 5-1-62	
22c. PHYSICIAN'S NAME (Type) JOHN C. Hyle		22d. ADDRESS 7527 Belair Rd Baltimore 36	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR MAY 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04353

04349

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>7yr6mth27dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Etta A. West</u>		4. DATE OF DEATH Month Day Year <u>April 19 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Frederick Schulte</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic nephritis</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 21, 1954</u> to <u>April 19, 1962</u> that I last saw the deceased alive on <u>April 19, 1962</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Loretta Y. F. Hsu</u>		DATE SIGNED <u>4-19-62</u>	
PHYSICIAN'S NAME (Type) <u>LORETTA Y. F. HSU</u>		ADDRESS <u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4-21-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Strong</u>		ADDRESS <u>3207 W. North Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04354

04350

1. PLACE OF DEATH a. COUNTY <u>Balto Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN lb <u>OVERLEA</u>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u> d. STREET ADDRESS <u>43 Ridgeway Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>WHELELLA</u> Last <u>WHELELLA</u>			4. DATE OF DEATH <u>APR 20 - 1962</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 6 - 1867</u>	9. AGE (In years last birthday) <u>94</u> yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Schaefer</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>John Wheeler</u>			Address <u>3013 Parktown Rd. 34</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery disease</u> (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2</u> <u>1956</u> , to <u>4/2</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> <u>1962</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Milton Schlenker</u>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Milton Schlenker, M.D.</u>			22d. ADDRESS <u>6416 Windsor Mill Rd Balto Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Apr 24 - 62</u>		<u>Baltimore Cem</u>	
23d. LOCATION (City, town or county)		(State)			
<u>Baltimore</u>		<u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>			25a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		
ADDRESS <u>7401 Belair Rd.</u>			25b. REGISTRAR'S SIGNATURE <u>William E. Funn</u>		



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

J.P.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04355

CERTIFICATE OF DEATH

04351

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
c. LENGTH OF STAY IN b. <u>10 days</u>		d. STREET ADDRESS <u>109 Chester Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>E.</u> Last <u>Wilde</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1894</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Wilde</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Edgar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 572.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Iliac and femoral vein thrombosis</u> (c) <u>Colon diverticulitis, purulent</u> DUE TO cause last, (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (X) (this hospital) attended the deceased from <u>March 22, 1962</u> to <u>April 9, 1962</u> , that (X) (we) last saw the deceased alive on <u>April 2, 1962</u> , and that death occurred at <u>7:35</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u>		22b. DATE SIGNED <u>4-10-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 12-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR <u>APR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Anthony L. Hanna</u>			



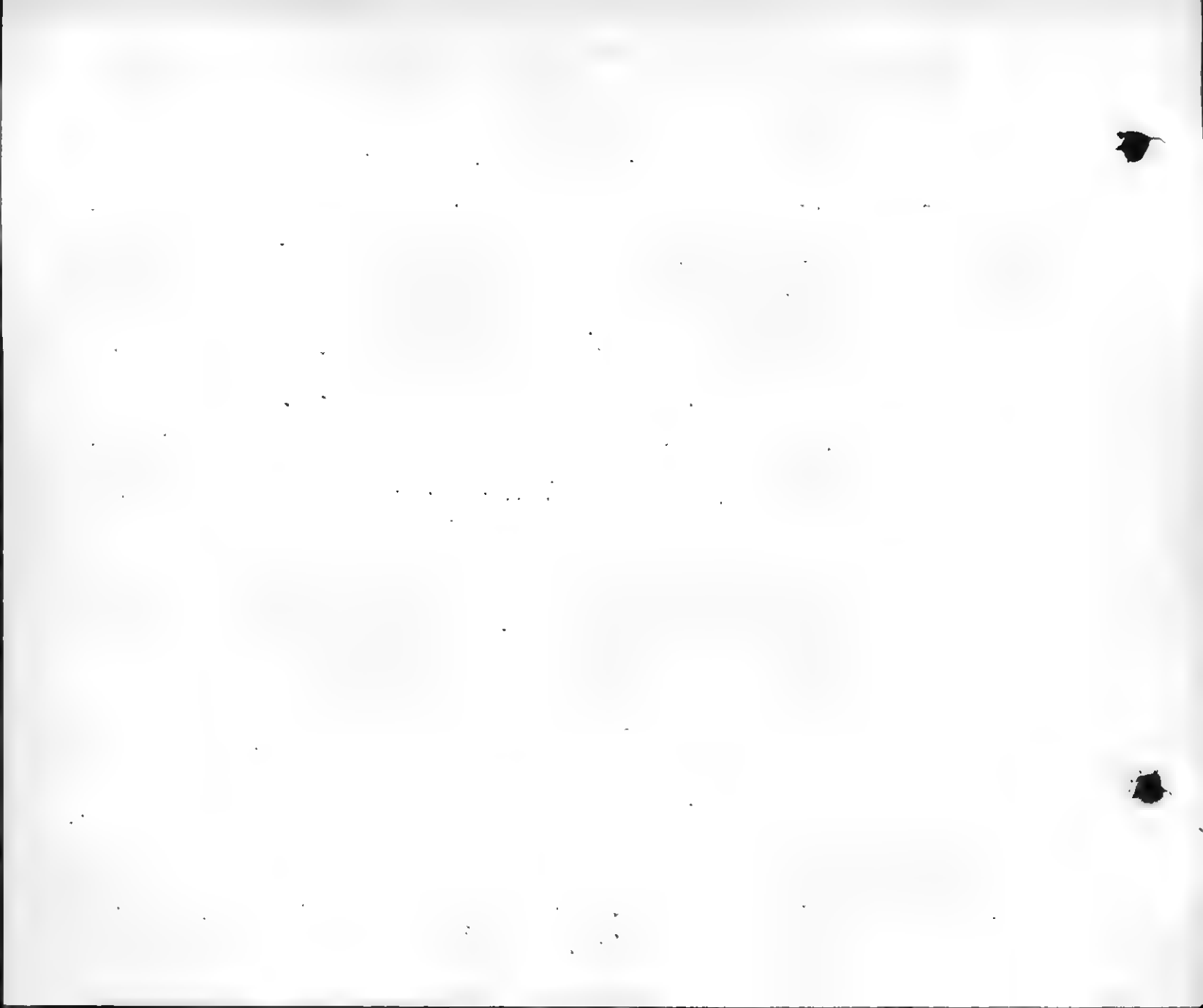
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04352

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco-Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco-Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Haletown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Resh</u> Middle <u>DUNCAN</u> Last <u>Wilhelm</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob B. Wilhelm</u>		14. MOTHER'S MAIDEN NAME <u>Angelina M. Hale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>217-07-7292</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> <u> </u> <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u> <u>(?) about 1 month</u>	
18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u> </u> <u> </u> <u> </u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20e. (City or town) <u> </u>		20f. (County) <u> </u>	
20g. (State) <u> </u>		21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>61</u> , to <u>Apr 12</u> , 19 <u>62</u> that I last saw the deceased alive on <u>July 31</u> , 19 <u>61</u> , and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7 Hampstead Rd.</u> DATE SIGNED <u>4/12/62</u>	
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		PHYSICIAN'S NAME (Type) <u>Joseph E. Bush, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-14-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Prince</u>		24a. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
ADDRESS <u>Hampstead Rd</u>		DATE <u>APR 16 '62</u>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

304357

04353

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN IL <u>41 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>T.</u> Last <u>WILLIAMS</u>		f. STREET ADDRESS <u>939 Coleridge Road</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/25/91</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marine</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Elizabeth City, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Brothers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>091-14-2760</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>BILATERAL BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>2/27/1962</u> to <u>4/9/1962</u> , that (1) (we) last saw the deceased alive on <u>4/9/1962</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE SIGNED <u>4/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M. D.</u>		22d. ADDRESS <u>VAH, FT. HOWARD, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/13/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors</u>		25a. REC'D BY REGISTRAR <u>APR 12 '62</u>	
ADDRESS <u>4101 Edmondson Avenue Baltimore, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

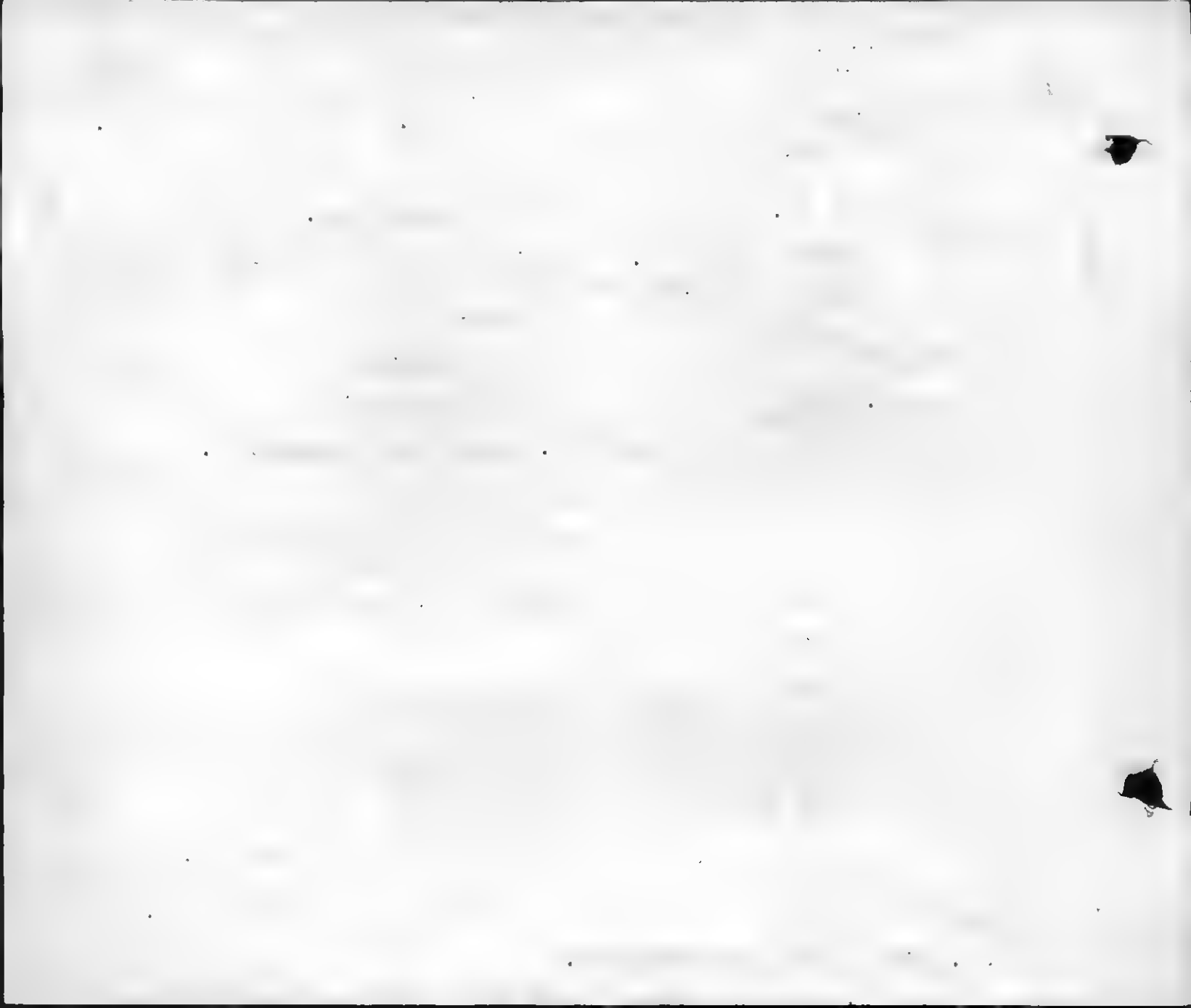
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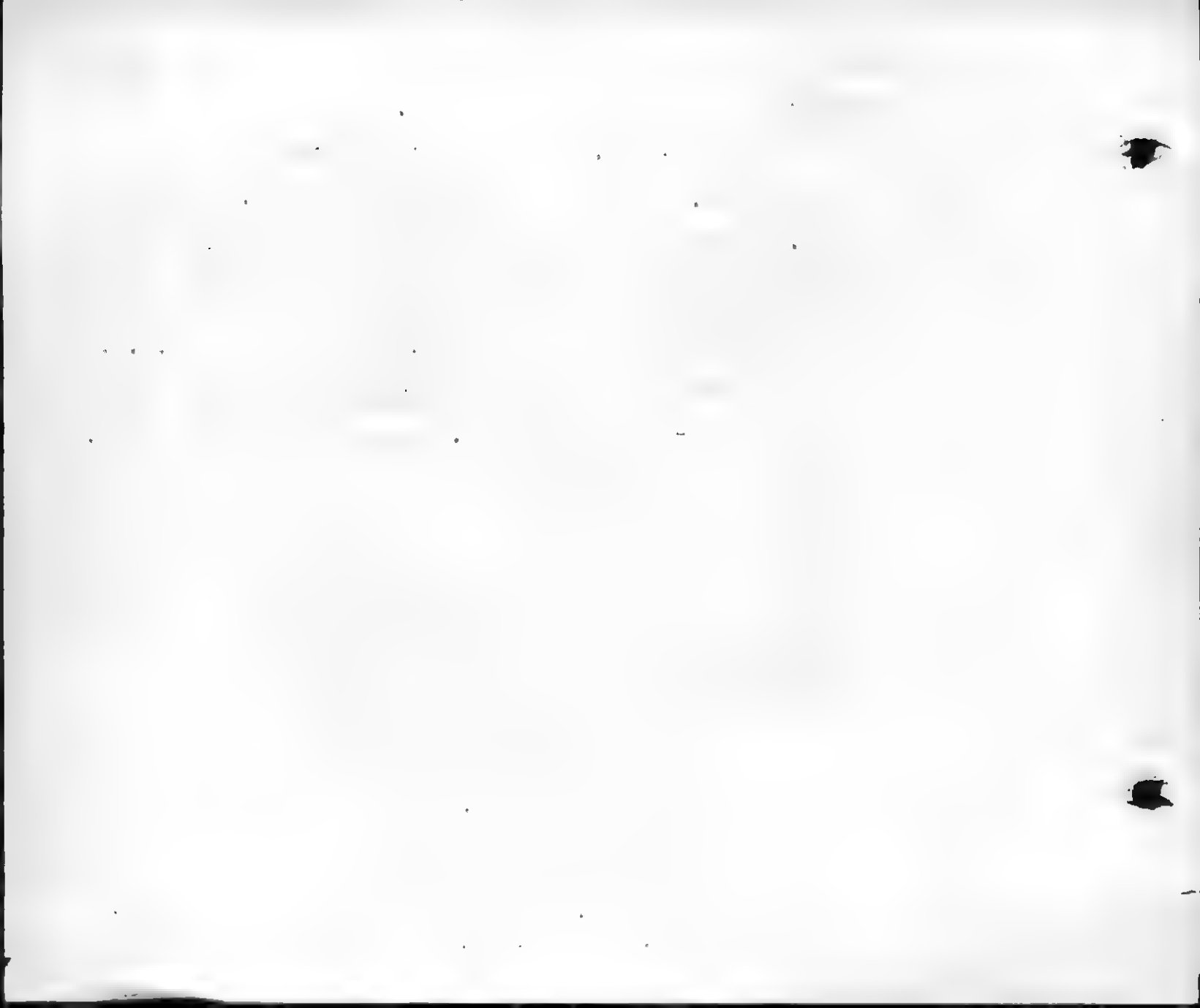
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04358
CERTIFICATE OF DEATH
04354

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glyndon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Chatsworth Ave.		d. STREET ADDRESS 2 Chatsworth Ave.	
3. NAME OF DECEASED (Type or print) Frances H. Wilson		4. DATE OF DEATH Month April Day 4 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 72 yrs. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles V. Hummel		14. MOTHER'S MAIDEN NAME Emma Meredith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Donald Wilson		Address Glyndon, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Hypertensive C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
INTERVAL BETWEEN ONSET AND DEATH 10 min. 6 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that (I) (we) attended the deceased from 1-13-56 , 19 to Apr. 4 , 1962 , that (I) (we) last saw the deceased alive on 3-24-62 , 19 , and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
22a. SIGNATURE D. D. Caples		22b. DATE SIGNED 4-6-62	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/62	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		25a. REC'D BY REGISTRAR APR 9 '62	
ADDRESS Reisterstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma	





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04350

04356

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN IL <u>10 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 LINDEN TERRACE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>108 LINDEN TERRACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First Middle Last 4. DATE OF DEATH <u>APRIL 29 1962</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>DEC 19, 1880</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> yrs. Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXECUTIVE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER COMPANY</u> 11. BIRTHPLACE (County & State, or foreign country) <u>DANVILLE, OHIO</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>THEODORE WORKMAN</u> 14. MOTHER'S MAIDEN NAME <u>ALICE WHEATON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>274-05-6454</u> 17. INFORMANT <u>MRS CRYSTAL GILLESPIE</u> Address <u>108 LINDEN TERRACE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma (undifferentiated) of lung with metastases to cervical lymph nodes and through neck structures generally</u> Conditions, if any, which gave rise to immediate cause (b) <u>2 years</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anterosegmental heart disease with cardiac hypertrophy and atherosclerosis</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of form 18.) <u>fibulation</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1958</u> to <u>April 29, 1962</u> that (I) (we) last saw the deceased alive on <u>April 26, 1962</u> and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard N. Tillman</u> 22c. PHYSICIAN'S NAME (Type) <u>RICHARD N. TILLMAN, MD</u>		22b. ADDRESS <u>3035 St. Paul St Baltimore, MD 21218</u> 22d. ADDRESS <u>3035 St. Paul St Baltimore, MD 21218</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MAY 2, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NORTH CANTON CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>CANTON, OHIO</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS</u> ADDRESS <u>4905 YORK RD BALT 12, MD</u> 25a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04361

04357

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Haward</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westmeir</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
c. LENGTH OF STAY IN 1b <u>3 mos</u>		d. STREET ADDRESS <u>Folly Quarter Farm</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1211 Baker Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1962</u>	
First <u>Rebecca</u> Middle <u>Worley</u> Last <u>Worley</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-75</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Haward Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George A. Dumhart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Harding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>2901 Sheridan St</u>	
17. INFORMANT <u>Thamark W. Worley</u>		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.U.A.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-22</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 9, 1962</u> to <u>Apr 7, 1962</u> that (I) (we) last saw the deceased alive on <u>Apr 7, 1962</u> and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>James G. Howell</u> M.D.	
22b. DATE SIGNED <u>4-7-62</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES G. HOWELL</u>	
22d. ADDRESS <u>Catonville</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>4/10/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>	
23d. LOCATION (City, town or county) (State) <u>Seagoville Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canaleason, Rural, Md</u>	
25a. REC'D BY REGISTRAR <u>APR 11 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10433

10630

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04362

CERTIFICATE OF DEATH

04358

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Woodlawn, 7		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Woodlawn, 7	
c. LENGTH OF STAY IN lb 30 yrs.		d. STREET ADDRESS 1920 Englewood Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1920 Englewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Earl O Zentz		4. DATE OF DEATH Month April Day 16 Year 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1884
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		9b. AGE (In years last birthday) yrs. 77	
10b. KIND OF BUSINESS OR INDUSTRY Fertilizer Bus.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
13. FATHER'S NAME William F. Zentz		14. MOTHER'S MAIDEN NAME Katura Virginia Griffe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-05-9514	
17. INFORMANT Mrs. Bertha B. Zentz, Baltimore 7, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-22-62	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 4-14-1962 to 4-16-1962 that (I) (we) last saw the deceased alive on 4-10-1962 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Samuel Blumenfeld		22b. DATE SIGNED 4-17-62	
22c. PHYSICIAN'S NAME (Type) Dr. Samuel Blumenfeld		22d. ADDRESS 2104 Gwynn Oak Ave., Balto. 7, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-62	
23c. NAME OF CEMETERY OR CREMATORY Krieders Cemetery		23d. LOCATION (City, town or county) (State) Carroll County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR APR 18 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

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